HEALTH PLAN REFERENCE GUIDE

HEALTH | DENTAL | VISION

CALIFORNIA SMALL GROUP

SUMMER 2020

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HEALTH PLAN REFERENCE GUIDE

The Health Plan Reference Guide (HPRG) is a compilation of Carrier Plans and Services offered to you through Word & Brown. The HPRG provides brokers with information on plan commissions, benefits, enrollment and eligibility requirements and coverage areas. This information is printed on a quarterly basis and the most up to date guidelines are posted on our website.

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TO OUR BROKERS:

The information in this publication was collected from carriers marketed through Word & Brown and is accurate to the best of our knowledge at the time of printing. However, since this publication is intended strictly as a guide, and plan specifications may change, we recommend that you verify any data with your Word & Brown sales representative and the carrier before making a decision on the information provided. Word & Brown disclaims any and all liability regarding the errors or omissions of the carriers. You further acknowledge and agree that Word & Brown disclaims any and all liability regarding the accuracy and reliability of the information contained in this publication and you will defend, indemnify and hold harmless Word & Brown, its affiliates and assigns against any liability arising therefrom.

***Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

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HELPFUL TRANSITION TIPS FOR YOUR CLIENTS

Please share these tips with all of your clients changing insurance plans

Until the new insurance plan has been approved, please make sure your clients are aware of the following:

Emergency Care – In case of an emergency situation, your client should call 911 or go to the nearest hospital* and pay cash or use a credit card for any incurred fees. Once their group is approved by the carrier, they can request reimbursement (less their plan's emergency room co-payment). Also remind clients to keep a record of their payment for submission to the carrier. Some plans waive the emergency room co-payment if the patient is admitted to the hospital directly from the emergency room. Important: The diagnosis by the emergency room physician must meet the carrier's definition of a true emergency in order to receive any reimbursement.

* ***The Patient Protection and Affordable Care Act (PPACA) requires health plans to pay emergency services at in-network level even if provider is out of network. However, non-network providers may charge more than in-network contracted rate and member would be responsible for any charges over the in-network contracted rate.***

If your client is taken by car or ambulance to a non-network hospital because it's within closer proximity than an in-network hospital, the new carrier must be notified within 24-48 hours. Please have them call their company's insurance contact person or you, the broker, if they need assistance with this notification process.

Continuity of Care/Completion of Covered Services – If your client or their enrolling spouse/domestic partner is pregnant and receiving care from a non-network doctor, your client is undergoing treatment for an acute condition, a serious chronic condition or terminal illness by a non-network doctor or your client's newborn child is receiving care from a non-network doctor between birth and age 36 months, they may come under the provisions of the California law requiring carriers to provide continuity of care (completion of covered services) with the non-network doctor in specific circumstances. It is important that they notify their company's designated insurance contact person or you as soon as possible to get assistance with submitting the continuity of care form to the carrier if their situation meets this law's criteria and the carrier's program guidelines.

Doctor Office Visit – Some offices will allow the patient to sign a waiver and pay for the visit up front. Remind your client to keep a record of their payment for submission to the carrier along with their reimbursement form once they have their new ID number. If your client is a current patient, some doctors will agree to bill the new insurance carrier once the patient gets their new insurance ID number and will have them pay only the office visit co-pay for their new plan. It is best to call the office before their appointment and explain their situation so they know what the payment procedures are in advance. If this visit can be postponed without adverse consequences to their health, they may want to consider rescheduling their appointment for a later date when they have their new ID number.

NOTE: The Patient Protection and Affordable Care Act (PPACA) also requires health plans to cover Preventive Care with no cost sharing by members (no copays/ coinsurance). Check with your health plan carrier regarding what is included as preventive care.

Prescriptions – Clients should refill maintenance prescriptions prior to the effective date for their new coverage. For example, they should refill a maintenance high blood pressure medication no later than 12/31 for new coverage that will be effective 1/1. If they need to fill a prescription on or after the effective date for their new coverage, but they do not have their new ID number yet, they can pay for the prescription at the pharmacy and then request reimbursement from the carrier once they receive their new ID number. For reimbursement, they must submit the pharmacy receipt that includes the name of the drug & dosage rather than only the cash register receipt. If they paid for the prescription by credit or debit card, and return to the pharmacy with their ID number within 7-10 business days, some pharmacies will credit any overpayment back to their account. This is the fastest way for them to get their money back. When a medication is expensive, some pharmacies will work with the client by allowing them to buy a smaller amount (Ex: 10-day supply). When the client returns to pick up the remaining balance of their 30-day supply, the appropriate payment adjustment will be made once they show the pharmacy their new ID number. Some brand name drugs have generic equivalents that are much more cost effective. You or your client can find out if their prescription medication is name brand or generic (and the co-pay amount) by using the carrier's Web site RX search.

Once the plan is approved and your clients' employees have received their new membership cards:

- They should carry their membership card at all times. It is important for them to show their new ID card to their doctor during the first visit after their new insurance plan becomes effective.
- Your clients should always make sure they use an in-network doctor or an in-network hospital in order to maximize their coverage and prevent significant gaps in coverage and/or higher out of pocket expenses.
- You should encourage your clients to review all of the benefit descriptions they received during enrollment and their Explanation of Benefits booklets (which the carrier mails to their home address) so they are familiar with their co-payments and covered procedures.
- Ensure they are aware of which procedures will require prior authorization in their plan documents. Remember that procedures authorized with their previous carrier may require pre-authorization with their new carrier. Each carrier has their own criteria, so an authorization by one carrier does not guarantee authorization by another carrier in all circumstances.
- For any additional questions, your client should call Member Services (see specific carrier section in this book or their ID card for the phone number).

SMALL GROUP PRODUCTS & BROKER COMMISSIONS

CARRIER / PLAN	GROUP SIZE	COMMISSION
Aetna		
Medical	1-100	5% for annualized premium up to $1,000,000. Once annualized premium reaches $1,000,000, commissions will be paid at 1%.
Dental	2-50	Standalone – 9%; with Medical 10% for first year only
	51-100	10% [for all years]
Vision	2-100	10% *Broker commission will be reduced by any override to compensate General Agent.
Aflac (Individual Voluntary Plans)[1]		
Creative Solutions	3-99 Policy holders	Begins at 12% commission and increases with agent involvement and production [for all years].
Ameritas		
Dental	3-199	10% Level Simple Add-Ons - 10%
Vision	3+	10% Level Simple Add-Ons - 10%
Anthem Blue Cross		
Medical	1-100	5% First $1,000,000 0.8% Over $1,000,000 [for all years]
Dental and Vision	2-100	10% [for all years]
Life	2-100	15% [for all years]
Voluntary/Optional Life and AD&D	10-100	15% [for all years]
STD, LTD, Vol. STD and Vol. LTD	10-100	15% Flat [for all years]
Avesis		
Vision	2-100	10% [for all years]
BEST Life and Health Insurance Company[2]		
Dental	2-50 51-99	10% [for all years] 8% [for all years]
Voluntary Dental	5-50 51-99	10% [for all years] 8% [for all years]
Vision	5-99	10% [for all years]
Life and AD&D	2-99	15% [for all years]
Blue Shield of California		
Medical	1-100	5% [for all years]
Medical (Mirror Package)	1-100	5% [for all years]
Dental and Vision	1-100	10% [for all years]
Life	2-100	10% [for all years]
CalCPA		
Medical (Anthem Blue Cross)	1-50	7%
Dental (Delta Dental)	2+	10% [for all years]
Vision (VSP)	2+	10% [for all years]

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CARRIER / PLAN	GROUP SIZE	COMMISSION
CaliforniaChoice® (Employee Choice) Medical		
Medical	1-100 (medically enrolled)	5%
Dental, Vol. Vision and Life	2-100	12% [for all years]
Chiropractic	2-100	6.5% [for all years]
California Dental Network		
Dental	2+	10% Flat unless otherwise requested [for all years]
Camden[1]		
Vision	5+	10% Flat [for all years]
Chinese Community Health Plan		
Medical	1-100	1st Year: 6.5% 2nd Year: 6.2% 3rd Year: 5.9% 4th Year: 5.6% 5th Year: 5.3% 6th Year+: 5.0% Annual Premium $500,001+: 1.0% -When annualized premium for a single group reaches $500,001 or more in a contract year, the commission is reduced to 1.0% for amounts over $500,001 for that group.
	101+	5% or Negotiable [for all years]
ChoiceBuilder®		
Dental, Vision, Life and Chiropractic	2-199	10% [for all years]
CIGNA[1]		
Dental and Vision	26-250	Negotiable - Contact your Word & Brown representative
Colonial Life[1]		
Dental, Life, Disability, Accident, Critical Illness, Cancer and Hospital Confinement Indemnity	3+	Varies by product
CompNet[1]		
Creative Solutions	1-100	1st year: 4% Renewal: 3%
Delta Dental		
Dental	2-100	10% Flat [for all years]
Vision	5-100	10% Flat [for all years]
Delta Dental (MWG)[1]		
Dental	1-4	10% [for all years]
E.D.I.S.[1]		
Freedom Dental	2-50 51-100	10% 7.5%
Group Term Life	2+	10%
EDHP Hybrid, RBP and Buy Up Plans	2+	$6 PEPM, and the below % of both the specific and aggregate premium. • 8% if spec deductible is $10,000 • 9% if spec deductible is $20,000 • 10% if spec deductible is $30,000 or higher
EDHP MVP Plan	2+	$10 PEPM
MEC Plans	2+	$5 PEPM

(Continued)

SMALL GROUP PRODUCTS & BROKER COMMISSIONS

CARRIER / PLAN	GROUP SIZE	COMMISSION
Evolved Benefits[1]		
Staff Benefits Management and Administrators (SBMA)	25-100	Basic - $10 Virtual - $10 Ultra - $15 Ultimate - $15
Transamerica/ TransConnect	2-100	HP45 - 18%
Guardian[2]		
Dental, Vision, Life, STD, LTD, Accident, Critical Illness, Hospital Indemnity, Cancer	2-100	Standard M-Scale
Health Net		
Medical	1-100	5% [for all years]
Dental and Vision	2-100	10% [for all years]
Life	2-100	4% Level [for all years]
HealthiestYou[1]		
TeleHeath	1-100	15% [for all years]
Humana[1]		
Dental and Vision	1-100	First $10,000: 10% Next $10,000: 7.5% Next $10,000: 5% Next $20,000: 2.5% Over $50,000: 1.5%
Employer-Sponsored Group Life & AD&D	1-50 51-100	10% First $5,000: 15% Next $20,000: 10% Next $25,000: 7% Next $50,000: 3% Next $100,000: 2% Over $200,000: 1%
Voluntary Group Life and AD&D	1-100	15%
International Medical Group (IMG)[1]		
Alternative Solutions	1-100	Varies
Kaiser Permanente**		
Medical	1-100	5% [for all years] • For groups with aggregate premiums higher than $1,000,000 in any group year, commissions are at the above rate for premiums up to $1,000,000 and at 1% for premiums higher than $1,000,000 in that group year.
Dental (PPO)	1-100	$2.65 (per member per month)
Dental (HMO) DeltaCare	1-100	$1.32 (per member per month)
Landmark Healthplan[1]		
Chiropractic	2-199	10% [for all years]
Liberty Dental		
Dental (HMO)	2-300	10% [for all years]

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CARRIER / PLAN	GROUP SIZE	COMMISSION
Lincoln Financial Group[1]		
Dental	2-99	First $10,000 - 10.00% Next $10,000 - 8.00% Next $10,000 - 4.00% Next $20,000 - 2.00% Next $50,000 - 1.50% Next $150,000 - 0.25% Next $250,000 - 0.15% Above $500,000 - 0.15%
Vision	2-99	10%
LTD	2-99	First $15,000 - 15.00% Next $10,000 - 10.00% Next $25,000 - 5.00% Next $50,000 - 1.00% Above $100,000 - 0.50%
Life AD&D and STD	2-99	First $2,000 - 15.00% Next $3,000 - 12.00% Next $5,000 - 11.00% Next $5,000 - 8.00% Next $5,000 - 7.00% Next $5,000 - 6.00% Next $5,000 - 5.00% Next $20,000 - 2.00% Next $50,000 - 1.50% Next $50,000 - 1.00% Next $350,000 - 0.75% Above $500,000 - 0.50%
MediExcel Health Plan		
Medical	1-100	7% [for all years]
Dental	1-100	10% [for all years]
Vision	1-100	10% [for all years]
MetLife[2]		
PPO Dental PPO Vol. Dental	2-100 2-100	First $5,000: 10.00% Next $5,000: 7.50% Next $20,000: 5.00% Next $10,000: 3.50% Next $10,000: 3.00% Next $10,000: 2.00% Next $190,000: 1.75% Next $250,000: 1.00% Next $500,000: 0.50% Next $4,000,000: 0.25% Over $5,000,000: 0.10% [for all years]
MetLife Dental HMO/Managed Care, SafeGuard Dental DHMO & Vision	5-100	10% Level [for all years]
Life and STD	2-100	First $5,000: 15.00% Next $5,000: 10.00% Next $20,000: 5.00% Next $10,000: 3.50% Next $10,000: 3.00% Next $10,000: 2.00% Next $190,000: 1.75% Next $250,000: 1.00% Next $500,000: 0.50% Next $4,000,000: 0.25% Over $5,000,000: 0.10% [for all years]
LTD	5-100	First $15,000: 15.00% Next $10,000: 10.00% Next $25,000: 5.00% Next $200,000: 2.00% Over $250,000: 1.00% [for all years]

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SMALL GROUP PRODUCTS & BROKER COMMISSIONS

CARRIER / PLAN	GROUP SIZE	COMMISSION
National General[1]		
Medical	2-24 25-50 51-200	7.0% 6.0% 5.0%
Nippon Life Benefits[1]		
Medical	50-100	First $1,000: 6.50% Next $4,000: 4.70% Next $5,000: 2.85% Next $10,000: 2.60% Next $10,000: 2.35% Next $20,000: 1.85% Next $200,000: 1.15% Next $500,000: 0.55% Next $1,250,000: 0.28% Over $2,000,000: 0.10% -Flat commission % is negotiable, contact your Word & Brown representative
Dental	2-50 51-100	10% first year and renewal $0 - $10,000 = 10% $10,001 - $15,000 = 7.5% $15,001 - $20,000 = 7.5% $20,001 - $25,000 = 5.0% $25,001 - $50,000 = 5.0% $50,001 - $100,000 = 2.5% $100,001+ = 1.0%
Vision	2-50 51-100	10% first year and renewal $0 - $10,000 = 10% $10,001 - $15,000 = 7.5% $15,001 - $20,000 = 7.5% $20,001 - $25,000 = 5.0% $25,001 - $50,000 = 5.0% $50,001 - $100,000 = 2.5% $100,001+ = 1.0%
Life and AD&D	2-50 51-100	15% first year and renewal $0 - $10,000 = 15% $10,001 - $15,000 = 10% $15,001 - $20,000 = 10% $20,001 - $25,000 = 7.5% $25,001 - $50,000 = 7.5% $50,001 - $100,000 = 5% $100,001+ = 2.5%
STD	2-50 51-100	15% first year and renewal $0 - $10,000 = 10% $10,001 - $15,000 = 7.5% $15,001 - $20,000 = 7.5% $20,001 - $25,000 = 5.0% $25,001 - $50,000 = 5.0% $50,001 - $100,000 = 2.5% $100,001+ = 1.0%
LTD	2-50 51-100	15% first year and renewal $0 - $10,000 = 15% $10,001 - $15,000 = 15% $15,001 - $20,000 = 12.5% $20,001 - $25,000 = 12.5% $25,001 - $50,000 = 10% $50,001 - $100,000 = 10% $100,001+ = 5%
Nippon Life Benefits[1] - Affiliated Trust		
Medical/Rx/Vision	2-50	For the first $250,00 7% For the Next $250,00 5.5% Over $500,00 3.0%
Oscar		
Medical	1-100	5% of premium

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CARRIER / PLAN	GROUP SIZE	COMMISSION
Premier Access		
Dental	1-100	$0-10,000 – 10% $10,001 - $20,000 – 7.5% $20,001 – $30,000 – 5% $30,001 – $50,000 – 2.5% $50,001 - $250,000 – 1.5%
Premium Saver (MWG)[1]		
Creative Solutions	1-100	Zero to 15%. Contact your Word & Brown representative
Principal[2]		
Dental	3+ Voluntary: 5+	Graded beginning at 10%
Vision	3+ Voluntary: 5+	Graded beginning at 10%
LTD	3+ Voluntary: 5+	Graded beginning at 15%
STD	3+ Voluntary: 5+	Graded beginning at 10%
Life and AD&D	3+ Voluntary: 5+	Graded beginning at 10%
Accident	3+ Voluntary: 5+	65% 1st year; 5% 2nd year +
Critical Illness	3+ Voluntary: 5+	30% 1st year; 15% 2nd year +
Reliance Standard[1]		
Dental	2-19	10% [for all years]
Life	2-19	15% 1st year; 10% Renewal
LTD	2-19	15% 1st year; 10% Renewal
STD	2-19	10% [for all years]
Critical Illness & Accident	2-19	15% 1st year; 10% Renewal
Seniors Choice[1]		
Medical	1-100	8% [for all years]
Part D (RX)	1-100	5% [for all years]
Dental	1-100	10%
Vision	1-100	10%
Sharp Health Plan		
Medical (HMO)	1-100	Up to 5% of Paid Premium Mirrored Plans: 1st Year - 6.5% of Paid Premium 2nd Year - 6.2% of Paid Premium 3rd Year - 5.9% of Paid Premium 4th Year - 5.6% of Paid Premium 5th Year - 5.3% of Paid Premium 6+ Years - 5.0% of Paid Premium
Medical (PPO)	1-100	Contact your Word & Brown representative
SIMNSA		
Medical and Dental	1-100	7% Flat [for all plan years]
SmileSaver/MetLife DHMO		
Dental	2-999	SmileSaver DHMO: 10% Level
Sutter Health Plus		
Medical	1-50 51-100	6.5% 5%

(Continued)

SMALL GROUP PRODUCTS & BROKER COMMISSIONS

CARRIER / PLAN	GROUP SIZE	COMMISSION
UnitedHealthcare		
Medical	1-100	Flat 5%
Dental	2-100	2-50: 10% 51+ commission can vary at the request of agent or customer.
Vision	2-100	10% [for all years]
Life	2-100	10% [for all years]
STD & LTD	2-100	First $15,000: 15% Next $10,000: 10% Next $25,000: 5% Over $50,000: 1% [for all years]
Unum[1]		
Dental	5+	10% [for all years]
Group Term Life and AD&D	2+	First $15K - 10% Next $10K - 7% Next $25K - 5% Next $50K - 1% $100K+ - 0.5% [for all years]
Group Term Life and AD&D Voluntary	10+	15% [for all years]
LTD	2+	First $15K - 15% Next $10K - 10% Next $25K - 5% $50K+ - 1% [for all years]
STD	10+	First $15K - 10% Next $10K - 7% Next $25K - 5% Next $50K - 1% $100K - 0.5% [for all years]
LTD Voluntary and STD Voluntary	10+	15% [for all years]
Vision Plan of America		
Vision	2+	10% Flat [for all years]
VSP[2]		
Vision (Voluntary)	10+	First $5,000: 10% Next $5,000: 5% Next $10,000: 3.56% Next $10,000: 3% Next $20,000: 2.31% Next $200,000: 1.44% Next $250,000: 0.73% Exceeding $500,000: 0.35% [for all years]
Vision (Employer Paid)	5+	First $5,000: 10% Next $5,000: 5% Next $10,000: 3.56% Next $10,000: 3% Next $20,000: 2.31% Next $200,000: 1.44% Next $250,000: 0.73% Exceeding $500,000: 0.35% [for all years]
Western Health Advantage		
Medical	1-100	Transition groups (51-100): Lock in flat 6.5% All New Small Groups (1-100): Flat 5%
Dental (via Delta Dental)	1-100	7.0% [for all years]

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BROKER OF RECORD CHANGE REQUIREMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health†	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Need original Broker of Record change letter on company letterhead or copy ok?	*Copy*	*Copy*	*Copy*	*Copy or fax of letter is required*	*Copy*	*Company letterhead is required*	*Copy*	*Copy*	*Copy*
Send Broker of Record change letter to (dept name + fax # or mailing address)	*Aetna Answer Team: 800-343-6101 or 844-250-9110 (fax) or NationalSSCSmallGroup@aetna.com*	*Sales Support 877-255-4015*	*Sales Support 877-255-4015*	*Banyan Administrators: fax: 877-237-4519 email: calcpahealth@fnrm.com*	*Finance 714-972-7368*	*Sales Dept 445 Grant Ave #700, San Francisco, CA 94108 415-955-8819 brokers@cchphealthplan.com*	*Broker Services 888-886-7973*	*Single Fax # for SBG Account Management: CA SBG Statewide Fax 800-303-3110*	*Fax Broker of Record changes to (800) 369-8010. For other compensation questions contact Broker Administration at (800) 440-2323.*
Turn around time for processing this change	*7-10 business days*	*7-10 business days*	*7-10 business days*	*2 business days*	*7-14 business days (15 day rescission period)*	*Up to 14 business days*	*7-10 days (10 day rescission period)*	*5-7 business days*	*14 business days*
Does carrier notify existing broker of this requested change?	*As a courtesy, Aetna notifies the broker after the change is processed via letter - advising them that they have been removed as the broker of record at the customer's request*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Effective date for new broker if group does not rescind this change request is prior agent vested? If yes, how long	*1st of the month following receipt*	*1st of following month*	*1st of following month*	*-If request is received before the 15th of the month, it will be effective on the first of the next month. -If request is received on or after the 15th of the month, it will be effective on the first of the month following a one month period. -Please note that this relates to the effective date of commissions. Commissions are paid to the new broker for premiums received on or after the commissions effective date. The broker can start acting on behalf of the firm as soon as we get the request.*	*1st of following month*	*1st of following month*	*1st of following month*	*1st of following month*	*The date on the BOR letter must be on or before the 1st of the month and be received by KP within the first 5 business days of the month for it to be effective that month*
Is prior agent vested? If yes, how long?	*No*	*No*	*No*	*No*	*Yes— for the first 6 months*	*No*	*No*	*No*	*No*

† *Broker of Record changes apply to Word & Brown agents business ONLY*

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BROKER OF RECORD CHANGE REQUIREMENTS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Need original Broker of Record change letter on company letterhead or copy ok?	*Copy*	*Copy is o.k.*	*Copy OK*	*Copy*	*Yes, we require the BOR on a company letterhead or copy.*	*Copy*	*Copy*	*Copy*
Send Broker of Record change letter to (dept name + fax # or mailing address)	*rfp@ mediexcel.com*	*Email (strongly preferred): sflicensing@ ngic.com* *Mail to: National General Benefits Solutions Group Retention- 3rd Floor 501 W. Michigan St. Milwaukee, WI 53203*	*brokers@ hioscar.com*	*Sales Dept. 858-499-8246*	*RFP@ simnsa.com*	*Broker Services Department 916-736-5418 shpbroker@ sutterhealth.org*	*Group Size 2-100: Renewal Account Executive*	*Sales Department Email: WHASales@ westernhealth.com or Fax: 916-568-1338*
Turn around time for processing this change	*48 hours*	*On average 60 days, unless the group is in their first plan year*	*5 days*	*7-10 business days*	*1-2 business days*	*3-5 business days provided new BOR is appointed with SHP*	*10 business days*	*5 Business Days*
Does carrier notify existing broker of this requested change?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Effective date for new broker if group does not rescind this change request is prior agent vested? If yes, how long	*1st day of month following receipt of notification.*	*For new groups, the new BOR change will not be in effect for commissions until the group has reached their first anniversary. Otherwise, we need 60 days notice*	*1st of month following the date of change request*	*1st of following month unless requested during the 1st week of month to be effective that month*	*1st of the month unless otherwise requested*	*1st of the following month*	*1st of following month*	*1st of the following month*
Is prior agent vested? **If yes, how long?**	*No*	*No*	*No*	*No*	*No*	*No*	*No*	*No*

	FSA	HRA	HSA
Definition	A flexible spending account (FSA) is an employee and/or employer-funded account for qualifying medical expenses.	A health reimbursement arrangement (HRA) is an employer-funded medical expense reimbursement plan for qualifying medical expenses. IRS regulations affect the plan design of many HRAs.*	A health savings account (HSA) is an employer and/or employee-funded account in the employee's name (eligible individual) for current and future medical expenses – requires a qualifying high deductible health plan (HDHP) and a qualified trustee or custodian. Other individuals may also contribute funds on behalf of the account holder.
Qualifications	Any size group (Only common-law employees can participate.)	Any size group (Only common-law employees can participate on a tax-free basis.)	Any size employer (Only eligible individuals can establish an HSA.)
Employer Tax Savings	Contributions are tax deductible when paid to the participant to reimburse an expense. As a result of salary reductions, lower adjusted employee income reduces employer matching FICA.	Contributions are tax deductible when paid to the participant to reimburse an expense.	Contributions are tax deductible in the year the contribution is made.
Employee Tax Savings	Contributions are made pre-tax. Reimbursements for eligible expenses are excluded from income.	Reimbursements for eligible expenses are excluded from income.	Contributions can be pre-tax or tax deductible on the employee's personal tax return. Funds earn interest tax-free. Reimbursements for qualified medical expenses are excluded from income. Employee may withdraw funds for non-medical expenses subject to income and excise tax.
Who Owns Unused Funds?	If funds attributable to employee pre-tax salary reductions, the plan owns (if an ERISA plan).	Employer (unless benefits paid from a trust)	Employee (eligible individual name on the established trust account)
Are Funds Portable?	No	No – however, it may have a post-termination spend-down feature.	Yes – funds belong to the employee (eligible individual)
Do Funds Carry Over?	Yes - an employer may allow employees to carry over up to $500 of unused health FSA funds to the following plan year (this is not required). However, the health FSA plan cannot have both a carryover feature and grace period. If the employer chooses to establish a grace period, it will follow the end of the plan year and may not exceed two months and 15 days. Unused FSA funds may be used to reimburse eligible expenses incurred during the grace period.	Yes, if employer specifies	Yes
Funding Requirement	Uniform coverage rule applies – claims must be paid without regard to amount contributed.	Not required to prefund – uniform coverage rule does not apply.	Funds must be present before withdrawal is made. Employer may contribute to HSA periodically or all at once.
Deductibles	A health FSA is not subject to a minimum deductible. A health FSA may be offered in conjunction with a high deductible health plan; however, the deductible amount is established by employer.	Generally, an HRA is not subject to a minimum deductible. An HRA may be integrated with a high deductible health plan; however, deductible amount is established by employer.	$1,400 minimum HDHP deductible (single) $2,800 minimum HDHP deductible (family)
Maximum Out-of-pocket	Employer sets funding levels.	Employer sets funding levels.	$6,900 maximum HDHP deductible (single) $13,800 maximum HDHP deductible (family)
Maximum Annual Contribution	Health FSA limit is $2,750** – however, an employer may establish lesser plan limits.	No – however, an employer may establish annual plan limits.	$3,550 max. contribution (single)*** $7,100 max. contribution (family)*** $1,000 max. catch-up contribution (individuals age 55 or older)
Allowable Expenses and Plan Restrictions	FSA can be offered alone or in conjunction with a major medical plan. Plan allows otherwise unreimbursed Code 213(d) medical expense excluding premiums and qualified long-term care services. Employer may restrict scope of reimbursements by plan design. If participant also has an HSA, the FSA must be limited to the following: qualified dental expenses, vision expenses, prescription drugs, and expenses constituting preventive care.	HRA allows otherwise unreimbursed Code 213(d) medical expenses including health insurance premiums. Generally, HRA may not reimburse expenses for qualified long-term care services. Employer may restrict scope of reimbursements by plan design (many plans limit reimbursement to deductibles, co-payments, co-insurance). If participant also has an HSA, the HRA must be limited to the following: qualified dental expenses, vision expenses, prescription drugs, expenses constituting preventive care, qualified insurance premiums, "suspended HRA," and retiree-only HRA.	HSA can only be established by any individual who is covered under a qualifying HDHP (as defined in Code §223 and with a deductible meeting the statutory limit), is not entitled to Medicare, and cannot be claimed as a tax dependent. Account holder cannot have disqualifying non-high deductible health plan coverage. Individuals who are entitled to Medicare cannot establish or contribute to an HSA. HSA allows otherwise unreimbursed medical Code Section 213(d) expenses excluding most premiums. An employer cannot restrict the scope of HSA distributions except for expenses paid with an electronic debit card so long as account holder has other means to obtain funds from HSA. Qualified expenses must be incurred after the HSA is established.
Administration	WageWorks	WageWorks	WageWorks, health insurance carrier, bank, TPA
Non-Medical Withdrawals	No	No	Taxable and subject to 20% penalty (no penalty if age 65 or older or disabled as defined by Code Section 72)

QUALIFYING EXPENSES UNDER AN FSA, HRA, OR HSA

Health FSAs and HRAs are generally subject to IRS Code Section 105. Therefore, only expenses that qualify as medical care under Code Section 213(d) are eligible for reimbursement, subject to some additional restrictions:

- Health FSAs cannot reimburse expenses for qualified long-term care services and/or insurance premiums (in accordance with Code Section 106 and 125); and
- HRAs cannot reimburse expenses for qualified long-term care services (in accordance with Code Section 106).

HSAs are subject to Code Section 223. Therefore, only expenses that qualify as "medical care" under Code Section 213(d) are eligible for tax-free reimbursement, except as otherwise limited by Code Section 223:

- No insurance premiums except for long-term care premiums, COBRA premiums, health coverage received while receiving unemployment compensation, and any deductible health insurance coverage for individuals who are age 65 or older (other than Medicare supplemental policies).

QUALIFYING MEDICAL EXPENSES

Qualified expenses must be for out-of-pocket medical care for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, including, but not limited to:

Acupuncture
Ambulance services
Artificial limbs and teeth
Automobile modifications (hand controls, special equipment, mechanical lifts if for individuals with disabilities)
Braille books and magazines
Contact lenses and solutions
Crutches and slings
Doctor co-pays
Eligible over-the-counter (OTC) medications**** and health care items
Examination, physical
Eye examination
Hearing devices
Hospital bills for medical care
Iron lungs (operating cost)
Laetrile (when prescribed by doctor)
Laser eye surgery
Lip reading lessons for the hearing impaired
Nursing care
Obstetrical (OB) expenses
Oxygen equipment
Prescription drugs for medical care
Prescription eyeglasses
Rental of medical or healing equipment (requires doctor's note)
Service animals
Surgery (except cosmetic surgery)
Telephones for the hearing impaired
Transportation expense related to medical care (including doctor's office)
X-rays

Qualified expenses also include fees paid to the following providers for treatment of a specific disease or medical condition:

Chiropodist (expense)
Chiropractor
Clinic
Dentist
Doctor
Gynecologist
Hospital
Laboratory
Midwife
Nurse
Obstetrician
Oculist
Ophthalmologist
Optician
Optometrist
Oral surgeon
Orthopedist
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Practical nurse
Psychiatrist
Psychoanalyst
Psychologist
Psychopathologist
Specialist
Surgeon

Ineligible expenses include: cosmetic surgery for non-medical reasons (including liposuction, hair transplants and electrolysis) and weight-loss programs (unless physician prescribed for treatment of a specific illness, including obesity).

FSA expenses must be incurred (i.e., services rendered) during the plan year.

HSA funds can be withdrawn for other purposes; however, the withdrawal amount will be subject to taxes and penalties. HSA account holders should consult their tax advisor for more information.

The information in this document represents a summary of information only and does not constitute a guarantee of any benefit nor limit our ability to require additional substantiation of a claim. For complete details on the health plan's benefits, limitations, and exclusions, refer to the Summary Plan Description. For details concerning a participant's rights and responsibilities with respect to an HSA (including information concerning the terms of eligibility, qualifying high deductible health plan, contributions to the HSA, and distributions from the HSA), please refer to the HSA Custodial Agreement.

Please refer to the published IRS documents for specifics. Health FSAs and HRAs are covered under IRS Section 105 and 106. Health FSAs are subject to additional rules set forth in the regulations under IRS Code Section 125. HRAs are subject to additional rules set forth in Notice 2002-45 and Rev. Rul. 2002-41. HSAs were established under the Medicare Reform Package, covered under IRS Code Section 223.

*Please consult your legal counsel to ensure your HRA plan design is permissible.
**Maximum annual limits for health FSA salary reductions became effective on January 1, 2013, and the initial limit was $2,500. The maximum limit may be indexed for inflation each tax year.
***Maximum contribution requires either full-year eligibility or initial eligibility as of December 1 of that year and continuation of eligibility throughout the following year.
****OTC medicines and drugs require a doctor's prescription to be eligible for reimbursement under a health FSA, HRA, or HSA. A list of eligible expenses is online at **www.wageworks.com**.

PHARMACY BIN & PCN NUMBERS

The Rx BIN number is a 6-digit number health plans use to process electronic pharmacy claims. Rx BIN and PCN numbers are used by new members to pick up a new prescription (or refill) prior to having a new ID card or showing up in the new Carrier's Rx system. Often the Rx system is separate from the Carrier's medical system, so it typically takes another 24-48 hours for members to show up in the Rx system. Please refer to the ID numbers below, if necessary, to re-order prescriptions during this short transition period.

	Rx BIN Number		PCN
Aetna	Rx BIN: 610502 Rx Group: Aetna		PCN: 00670000
Anthem Blue Cross	Rx BIN: 020099		PCN: IS
Blue Shield of California	Rx BIN: 600428		PCN: 1910000
Chinese Community Health Plan	RX BIN: 003585		RX PCN: ASPROD1
Health Net*	Rx BIN: 004336		PCN: HNET
Kaiser Permanente-Northern CA	Rx BIN: 11842 Rx Group: NC Tax ID: 94-1340523	COB Address: P.O. Box 7012 Downey, CA 90242	Rx PCN for MMA: NCCMS Rx PCN for HDHP: NCHDP
Kaiser Permanente-Southern CA	Rx BIN: 11172 Rx Group: SC Tax ID: 94-1340523	COB Address: P.O. Box 7012 Downey, CA 90242	Rx PCN for MMA: SCCMS Rx PCN for HDHP: SCHP
MediExcel Health Plan	MediExcel Health Plan is a cross-border Health Plan. Members must obtain prescriptions at contracted pharmacies in Mexico. MediExcel Health Plan does not contract with any pharmacy in the U.S. MediExcel Health Plan will reimburse members for prescriptions obtained as direct result of an Emergency or Urgent Care Service in the U.S. minus their copay amount.		
National General	RX BIN: 017010 (Cigna)		PCN: 05190000 (Cigna)
Nippon Life	RX BIN: 004336		PCN: ADV
Oscar	RX BIN: 004336		PCN: ADV
Sharp Health Plan	Rx BIN: 004336		PCN: ADV
Sutter Health Plus	Rx BIN: 003858 RX Group: SHP8668		PCN: A4
UnitedHealthcare HMO	Rx Vendor: OPTUMRx Rx BIN: 610279 Rx PCN: 9999 Rx Grp: UHCNICE Service Number: 800-788-7871		
UnitedHealthcare PPO	Rx Vendor: OPTUMRx Rx Bin: 610279 Rx PCN: 9999 Rx Grp: UHCNICE Service Number: 800-788-7871		
UnitedHealthcare PPO (Large Group)	Rx Vendor: OPTUMRx Rx Bin: 610279 Rx PCN: 9999 Key Accounts Rx Grp: UHEALTH Service Number: 800-788-7871		
Western Health Advantage	Rx Vendor: OptumRx RX BIN 610011		PCN: IRX

2020 ACA COMPLIANCE CHECKLIST

As a broker, it often becomes your responsibility to verify that your customers are in compliance with legislation. To that end, we have created the following checklist as a summary of the general tasks associated with ACA compliance. Not all items will apply to every group, but a thorough understanding on your part will help you guide your clients correctly. A corresponding PowerPoint presentation and a training document are available to you for further help, just ask your Word & Brown Sales Representative.

Budget Considerations:

- ☐ Use our Group Size Calculator to determine whether employer had average of 50+ FT plus FTE employees in prior year. If they did, this employer is an ALE subject to Employer Mandate the following year.
- ☐ If an ALE, use our Affordability Calculator to determine whether coverage meets one of ACA Affordability Safe Harbors in order to prevent a penalty. (Note: Affordability percentage is 9.78% in 2020).
- ☐ Ask clients about commonly-owned companies for accurate employer size determination
- ☐ Collect accurate DOBs for dependents under age 21 due to child rating structure effective 1/1/2018
- ☐ If any clients just reached the 50+ FT plus FTE threshold for the first time, check eligibility for transition relief from employer penalty Jan - Mar if MEC with MV offered April 1. (one-time relief)
- ☐ Verify your clients are no longer paying directly for/reimbursing employees for individual health plans, unless the Employer sponsors a Qualified Small Employer HRA (QSEHRA), or Individual Coverage HRA (ICHRA). (Costly Penalty)
- ☐ Discuss impact of any upcoming minimum wage increases on affordability of coverage calculations and overall company budget

Health Plan Administration:

- ☐ Verify waiting periods do not exceed the 90-day limitation
- ☐ If clients have orientation period prior to waiting period verify it is no longer than one month
- ☐ Explain to 50+ FTE clients with variable hour employees who may or may not work FT how to set up their lookback measurement, administrative and stability periods
- ☐ If client is 50+ FTE review Large Group ACA Compliance checklist for additional considerations
- ☐ Check Health FSA documents to make sure they reflect the $2,750 limit and specify either FSA grace period or $500 carryover provision
- ☐ Verify all groups are meeting participation. If not, prepare for 11/15-12/15 Special Open Enrollment Window
- ☐ Verify all employers are applying 30-hour FT definition to determine eligibility for coverage
- ☐ Confirm employers aren't changing employees to 1099 to avoid the mandate
- ☐ Determine if use of PEO or staffing agency personnel increases employer size to 50+ FTE due to IRS common law employee rules

Documents for Employees:

- ☐ Deliver DOL-Mandated Notice (New Health Marketplace Coverage Options and Your Health Coverage) to new employees within 14-days of hire
- ☐ Deliver Summary of Benefits and Coverage (SBC) and Uniform Glossary at enrollment, renewal and to new hires
- ☐ Deliver 60-day notices of modification, if plan changes are made outside of renewal
- ☐ If employer had average of 50+ FT plus FTE employees in 2019, prepare to give copy of IRS Form 1095-C (for 2020) to FT employees by 1/31/2021.

If you do not understand a concept on this checklist or need assistance assuring your group has accomplished a particular goal, please contact your Word & Brown Sales Representative who can provide further support.

HEALTH CARE REFORM - CARRIER SPECIFIC RATING CHANGES

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Are new hires rated by their age at the time their group became effective or by their age at the time the new hire is added to the plan?	*Members enrolling after the effective date or renewal date, the rates are based on the age of the person as of the effective date of coverage.*	*New hires are rated by their age at the time the new hire is added to the plan.*	*At the age the new hire is added to the plan.*	*Yes—age as of the time the new hire is added to the plan.*	*New hires are rated by their age at the time they are added to the plan.*	*New hires are rated by their age at the time the new hire is added to the plan.*	*Call your Word & Brown representative*	*Their age at the time of their group's effective date.*	*A member's age as of the effective date of the group contract will be used for calculating rates. This age will be used for the full contract year and updated at renewal.*
If employer is not in service area, are employees who live in service area eligible?	*The group must be located within the product service area in order for employees to enroll on a plan.*	*No*	*No*	*No, Employer must be in CA for group to have coverage. If employer is outside of CA, group cannot have coverage.*	*Call your Word & Brown representative*	*Yes*	*Call your Word & Brown representative*	• *Ratings based on employer ZIP Code.* • *Employer selects plans.* • *Employer must choose products for employees that are available in the employees' location and the employer's location.* • *Employee must be within the service area of at least one of the employer's selected product(s).* • *Rates for the employee will be based on that product -- in the employer's rating region.* • *Live/ Work rule applies: employee must be within 30 miles of care at home OR at work.*	*If your company is located in California, but outside of service area or outside of California, only employees residing in our service area will be eligible for coverage.*
If so, how are the employees who live in service area rated?				*N/A*		*Rates are determined by using Employer's ZIP Code*			*Businesses located outside of California are assigned to rating area 4.*
If employer is located in service area but employee does not live in the service area, is employee eligible?	*The employee must live or work in the plan service area. Rates would be based on the employer ZIP Code.*	*Employees who live outside California may only be eligible for PPO plans in the Statewide Prudent Buyer Network and Select PPO Network. Approved out-of-state employees will be charged an area-rate based on the location of the employer's place of business.*	*Yes Blue Shield uses the live or work rule. The employee would be rated based on the employer ZIP Code.*	*Yes, If employee lives outside of CA, they may have coverage. More than 50% of enrolled employees must reside in CA.*	*Call your Word & Brown representative*	*Yes*	*Call your Word & Brown representative*	• *Ratings based on employer ZIP Code.* • *Employer selects plans.* • *Employer must choose products for employees that are available in the employees' location and the employer's location.* • *Employee must be within the service area of at least one of the employer's selected product(s).* • *Rates for the employee will be based on that product -- in the employer's rating region.* • *Live/ Work rule applies: employee must be within 30 miles of care at home OR at work.*	*Only employees working or living in the service area are eligible to enroll*
If so, how are the employees who do not live in service area rated?				*Rates are determined by using the firm's ZIP Code.*		*Rates are determined by using Employer's ZIP Code*			*N/A*
How do you handle quoting employers with multi-county zips?	*All rates are based on the employer's primary location.*	*We do not allow multi-county ZIP Codes. One employer address. If an employer is in a multi-county ZIP code, once the ZIP code is entered, the county needs be entered. Anthem confirms the county by using the US Postal site: http://www.usps.com*	*Blue Shield uses the physical location of the group where the majority of the employees work to determine the rating region. We use a Geocoding software to determine the exact county for the address.*	*If the employee's ZIP Code spans multiple counties, use the county in which the employee resides. Same rules apply when using employer county to determine rating area for non-CA employees.*	*Call your Word & Brown representative*	*Rate is based on the physical location of the group.*	*Call your Word & Brown representative*	*If an employer is in a multi-county ZIP code, health net will base their rates on the county their address resides. We confirm the county via US Postal site: http://www.usps.com.*	*If the business is located in California the rate is based on the physical address (ZIP Code and county) of the business. Groups outside California are assigned rating area 4.*

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HEALTH CARE REFORM - CARRIER SPECIFIC RATING CHANGES

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Are new hires rated by their age at the time their group became effective or by their age at the time the new hire is added to the plan?	*A member's age as of the effective date of the group contract will be used for calculating rates. This age will be used for the full contract year and updated at renewal.*	*New hires would pay the same tiered rate as other employees. They are not charged a different rate based on their age.*	*Age at time of enrollment/ effective date*	*Age at the time of enrollment/ effective date*	*New hires are rated by the age at the time of enrollment.*	*New hire rates are based on the employee's age at the time of enrollment/ effective date*	*For ACA plans: Age at the time of enrollment/ effective date*	*New hires are rated by the age at the time of enrollment.*
If employer is not in service area, are employees who live in service area eligible?	*No*	*A blended rate is provided to the group which incorporates all employees. If however the employer elects a different network for that service area, then another plan can be set up in which unique rates for that plan choice is provided*	*No*	*Employer must be in the service area.*	*No*	*Yes* *SHP will base the rating on the highest percentage of employees in one region; If two or more regions have the same number of employees, SHP will use the region with the higher-priced rating.*	*No, the Employer must be within the filed service area in order to quote/offer the product (based on Employer ZIP Code).*	*Yes*
If so, how are the employees who live in service area rated?				*Employer ZIP Code*				*Employer ZIP code*
If employer is located in service area but employee does not live in the service area, is employee eligible?	*Yes - Employee's worksite location must be in San Diego County or Imperial County.*	*Yes, employees who reside elsewhere in the country are eligible.* *There will be one set of rates provided to the group. The rates provided take into consideration the entire census*	*Yes, employees must live, work or reside in the service area to be eligible.*	*Only those working or living in service area are eligible to enroll*	*Yes*	*Employees must live, work, or reside within the SHP licensed service area to be eligible.*	*No, the employee is not eligible to enroll unless the live/work rule applies (PCP selected within a 30 mile radius of residential or primary workplace as outlined in the HMO EOC). All employees are rated from the Employer ZIP Code for all products.*	*Yes, if the member commutes to service area.*
If so, how are the employees who do not live in service area rated?	*N/A*				*SIMNSA uses a working rule, as long as they work out of San Diego or Imperial County they can enroll*	*Rates are based on the employer's ZIP code.*		*Rates are based on the employer's ZIP Code.*
How do you handle quoting employers with multi-county zips?	*Employer worksite location must be in San Diego or Imperial County.*	*We utilize the zip in which the main office is located*	*Rates are based on employer's primary location if primary location is outside of Oscar's service area, rates are based on region where majority of employees work.*	*HMO rates based on San Diego location*	*Only those companies that are based out of San Diego or Imperial County will qualify.*	*Please call your Word & Brown representative*	*The Employer's address listed on the Group Application (ZIP Code of Headquarter location).*	*If location is in area, use that region. If all locations are out of area, contact WHA Sales.*

HEALTH CARE REFORM - COVERAGE ELIGIBILITY

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
When a member marries - and they submit application to have spouse added, when does the coverage start?	*First of the month following Date of Marriage. If actual date of marriage is needed, Aetna will manually add the spouse as of DOM.*	*Coverage would be effective on the date of marriage if the completed ACA application is received within 60 days of the date of marriage.*	*Date of the Marriage.*	*First of the month following date of marriage.*	*Marriage: If all required documentation is received before the 16th day of the month of marriage, premiums are charged for the full month and coverage begins on the date of marriage. If all required documentation is received on or after the 16th day of the month of marriage, coverage begins on the 1st of the month following the date of receipt.* *Domestic Partnership: If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month in which the domestic partnership was established, coverage begins on the 1st of the month following the date of receipt.*	*First of the month following the date of marriage.*	*First of the month following the date of event.*	*The spouse becomes eligible the first of the month following the date application is received if received within 30 day of Qualifying Event.*	*New dependents must be added within 60 days of becoming eligible if the addition is because of marriage/ acquisition of partner, new birth, adoption or placement of adoption, involuntary loss of other coverage, dependent moved into the service area, and qualified medical child support order (QMCSO).*
Newborn child, adoption, etc. - when is baby added? (i.e. date of birth, first of the month in which the child was born, or first of the month following birth)?	*Newborns of subscribers are eligible on their date of birth. Adopted children are eligible on the date of the adoption.*	*Newborns are effective on the date of birth when a completed ACA application is received within 60 days of the date of birth. Example: an application to add the baby arrives within 60 days of the birth. Anthem will add the baby effective on June 23rd.* *An adopted child is effective on the date of adoption or placement for adoption if the completed ACA application is received within 60 days of the date of adoption or placement.* **A child who is in the process of being adopted is considered a legally adopted child if: Anthem receives legal evidence of intent to adopt or notification of physical custody. The subscriber has the authority to control the health care needs of the child. Has assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child adoption.*	*Newborns of subscribers are eligible on their date of birth. Adopted children are eligible on the date of the adoption.*	*Date of birth*	*If birth/date of placement occurred before the 16th of the month, coverage begins on 1st day of the month of the date of their birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the 1st of the following month. Coverage for the dependent begins on the 1st of the month following the birth/date of placement.*	*Date of birth/ adoption*	*Date of birth*	*Newborn: Date of birth* *For adoption, the effective date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care.*	*New dependents must be added within 60 days of becoming eligible if the addition is because of marriage/ acquisition of partner, new birth, adoption or placement of adoption, involuntary loss of other coverage, dependent moved into the service area, and qualified medical child support order (QMCSO).*

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HEALTH CARE REFORM - COVERAGE ELIGIBILITY

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
When a member marries - and they submit application to have spouse added, when does the coverage start?	*The first of the month following their application.*	*The first of the month following their application.*	*1st of the month following the Qualifying Life Event. Spouse must be added within 60 days of marriage.*	*First of the month following date of receipt.*	*First of the month following date of the event.*	*The first of the month following the date of receipt of application.*	*Date of the marriage (as long as the completed application to enroll a spouse is received by UHC within 60 days of the marriage).*	*First of the month following the event.*
Newborn child, adoption, etc. - when is baby added? (i.e. date of birth, first of the month in which the child was born, or first of the month following birth)?	*Newborns and adopted children are added first of month following the event.*	*Date of birth*	*Date of birth or date of adoption. Dependents must be added within 60 days of becoming eligible.*	*Date of birth unless otherwise specified (first of month following date of birth is other option).*	*Newborns of subscribers are eligible on their date of birth. Adopted children are eligible on the date of the adoption.*	*Date of birth or date of adoption. Dependents must be added within 60 days of becoming eligible.*	*Date of the event (as long as the completed application to enroll a spouse is received at UHC within 60 days of the event).*	*Newborns are added first of month following event. Adopted children are eligible on the date of the adoption.*

HEALTH CARE REFORM - COVERAGE ELIGIBILITY

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Does your health plan go by Calendar Year or Policy Year for deductibles?	*Aetna Small Group plans are Calendar Year.*	*All Anthem plans have Calendar Year deductibles and benefits.*	*Calendar Year*	*CalCPA Health plans follow a Calendar Year for deductibles.*	*Calendar Year (all Health Plans).*	*Calendar Year*	*HRA plans, we would follow the carrier policy. For our stop loss level funded plans, they are CYD.*	*Calendar Year for deductibles*	*Deductibles have a Calendar Year accumulation period.*
Does your health plan cover employees through the end of the month if termed mid-month?	*Terminations are end of the month for 1st of the month groups and 14th of the month for 15th of the month groups.*	*Yes, for example, if an employee's termination of employment is 3/6/19, the group coverage will end 4/1/19.*	*We ask groups to terminate employees at the end of the month that they work as we bill for the entire month, we do not prorate premium. In addition, it makes it easier for COBRA administration.*	*The health plans are always effective through the end of a particular month. For example, if a person's last day on the job was the 1st of the month, and he waived coverage effective the 2nd day of the month, his/her benefits would remain active through the last day of that same month. If, however, a person's last day of work was on the last day of the month, his benefits would terminate also on that same day at the end of that same month.*	*Yes, (all Health Plans).*	*Yes, through the end of the month*	*The employee would be covered until the end of the month*	*Employees are covered through the end of the month*	*Termination changes are effective on the 1st of the month. If the last day of employment is the 1st of the month, coverage will terminate on that date. Otherwise, coverage will terminate on the 1st of the following month. KP does not prorate.*

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HEALTH CARE REFORM - COVERAGE ELIGIBILITY

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Does your health plan go by Calendar Year or Policy Year for deductibles?	*Calendar Year*	*The group has the option to choose either Calendar Year or Policy Year for their deductible.*	*Calendar Year deductibles.*	*Our plans are Calendar Year.*	*No deductibles*	*Calendar Year*	*It is calendar year. If a member changes plans in the middle of the year, funds already met will be transferred in to the new plan.*	*Calendar Year for deductibles and OOP Maximums.*
Does your health plan cover employees through the end of the month if termed mid-month?	*Employees can only be termed at the end of the month. Coverage will remain in place until the last day of the requested term month*	*Employees on the health plan will be covered until the end of the month if terminated after the 1st of any given month.*	*When an employee terms the employer has a few options, which are, end of month, end of following month or end of previous month. Only in the case of death can the death date be an option.*	*Yes, we only have end of month term dates.*	*Coverage will term at the end of the month*	*Yes. SHP only has end of month termination dates.*	*This decision is made by the group when the policy is sold. On our master application there is a section where they specify when coverage will end after termination and also start after hire date*	*Yes, employee will be covered until the last day of the month if terminated mid-month.*

HEALTH CARE REFORM - HIPAA CERTIFICATION

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Will you voluntarily issue a coverage verification document to all members who cease their coverage?	*We are not producing HIPAA statements. Member Services can provide an eligibility letter.*	*Small group enrollment and billing can provide a letter of eligibility when requested for any member who ceases their coverage.*	*The "Coverage of Cancel Notice" is issued automatically when an employee is termed.*	*Anthem Blue Cross of CA will send a Certificate of Credible Coverage to all members after coverage has ceased if requested. They cannot be sent prior to the coverage termination date.*	*CaliforniaChoice will automatically send out term certs.*	*Proof of creditable coverage is issued automatically when an employee is termed.*	*E.D.I.S. will send a Certificate of Credible Coverage to all members after coverage has ceased if requested.*	*Health Net will issue a document confirming the close of coverage for a member.*	*Yes - Refer to KP Administrative Handbook.*
Will a verification of coverage document be available upon request? If so, please provide contact information.	*Member Services can provide an eligibility letter.*	*Yes, a letter of eligibility is available upon request from the group, broker and member.*	*Yes, send the request to small.group@blueshieldca.com.*	*Yes, they can be requested after the coverage termination date by calling Anthem at 888-209-7847.*	*Yes, through the Customer Service Department at 800-558-8003.*	*Yes Member Services office: 888-775-7888*	*Yes, please contact Member Services at 888-886-7973.*	*Yes, please contact Member Services at 800-361-3366. Number is also located on the back of the Health Net ID card.*	*Yes, members with an active membership status are also entitled to receive a HIPAA certificate of creditable coverage within a reasonable time following submission of their request to Member Services. For more information, call 800-464-4000.*
What type of documentation, if any, will you be requiring when you receive off-anniversary enrollment due to loss of coverage?	*Aetna does not require documentation. Form should note that add is due to a loss of coverage.*	*The best form to use for enrollments due to loss of coverage and/or qualified event would be the employee change forms. The employee change form allows the employee to outline their qualified event and no additional information is required as long as section B is completed. The employee application is really more for a new enrollment as opposed to outlining the employee/dependents qualifying event.*	*The coverage of cancel notice.*	*The member must complete the Employee Enrollment Form and note the termination date of the previous coverage.*	*Any one of the below: HIPAA Certificates, Certificates of group health plan coverage, letters from a carrier, letters from a verified TPA, COBRA Election document, or letter from member stating when the loss of coverage occurred and that it was beyond their control, along with "old" membership ID.*	*Proof of last coverage showing the last effective date.*	*Proof of last coverage showing the last effective date.*	*Varies. Please review the Special Enrollment Guide.*	*Standard enrollment forms. Refer to KP Administrative Handbook.*

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HEALTH CARE REFORM - HIPAA CERTIFICATION

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Will you voluntarily issue a coverage verification document to all members who cease their coverage?	*Available upon request.*	*Yes*	*No*	*Yes*	*Available upon request*	*Yes*	*CA 1-99 Fully Insured Groups: Yes, notification is sent automatically upon termination.* *CA 51-99 All Savers Groups: No, the Member can request "Proof of Lost Coverage" by calling UHC's member call center.*	*Available on request*
Will a verification of coverage document be available upon request? If so, please provide contact information.	*Please email: applications@mediexcel.com*	*Yes*	*Yes. Member should reach out to Member Service (855-672-2788). Broker should call the Broker Support Team (855-672-2713).*	*Yes, please contact Customer Care to request - 800-359-2002.*	*Please email: enrollment@simnsa.com*	*Yes. Members can reach out to Member Services at 855-315-5800.*	*CA 1-99 Fully Insured Groups: Yes, notification is sent automatically upon termination.* *CA 51-99 All Savers Groups: No, the Member can request "Proof of Lost Coverage" by calling UHC's member call center.*	*Yes, email request to eligibility@westernhealth.com.*
What type of documentation, if any, will you be requiring when you receive off-anniversary enrollment due to loss of coverage?	*Proof of loss of coverage, along with a completed enrollment form.*	*Proof of loss of coverage, along with a completed enrollment form.*	*Proof of loss of coverage, including a letter from the previous carrier and an employer or COBRA letter as applicable*	*Sharp will require proof that previous insurance coverage was termed.*	*We will require a loss coverage certification from the previous carrier.*	*Standard enrollment form.*	*None*	*WHA can either use a loss of coverage certificate from their previous carrier or the group can verify the loss.*

HEALTH CARE REFORM - PEDIATRIC DENTAL & VISION

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Do you send out a separate Pediatric Dental and Vision card to employee household (for those that have dependent coverage 18 and under)?	*No Separate ID Card. Medical ID card covers the Pediatric Dental/Vision.*	*No*	*Dental - No, included in the medical card.* *Vision - No, included in the medical card. A "generic" Vision Plan Information Card can be accessed online to assist in accessing care, or members can call 877-601-9083 for assistance.*	*Dental - Yes* *Vision - No*	*See PEDIATRIC COVERAGE starting on page 116*	*Dental - Yes* *Vision - No*	*N/A*	*For Pediatric dental, an ID card will be sent if there are eligible members enrolled. For pediatric vision, a separate ID card will not be sent, but member may access services using their Health Net medical ID card.*	*N/A*
Is the ID card under the Dependent's name?	*Aetna provides a Medical ID card for all members of the family.*	*No, ID card is under subscriber's name.*	*No, the ID card will be under the subscriber's name.*	*Yes*	*See PEDIATRIC COVERAGE starting on page 116*	*Yes*	*No, the ID card will be under the subscriber's name*	*Pediatric dental ID card will be in subscriber's name. The Dependent will receive a Health Net medical ID card in his/her name.*	*N/A*
If the employee has dependent children 18 and under and also enrolls in the group dental program, which plan is primary?	*Depends on how the Dentist bills. If they bill under the medical benefit, the medical benefit pays. If they bill under the dental benefit, the dental benefit pays.*	*If enrolled in D100, Pediatric Dental is Primary. If enrolled in D200, Pediatric Dental is Secondary.*	*The pediatric dental plan will be the primary payer.*	*The pediatric dental plan will be the primary payer.*	*See PEDIATRIC COVERAGE starting on page 116*	*Pediatric Dental is primary.*	*Pediatric Dental*	*Dental and vision buy-up is available for dependents under 18. For DPPO, the Pediatric plan is primary; there is no COB for pediatric vision.*	*N/A*
Is there coordination of benefits between the group dental plan and the Medical Pediatric Dental and Vision program?	*No, pediatric dental falls under Medical, and Medical and Dental do not coordinate benefits.*	*Dental - Yes* *Vision - No*	*Dental - Yes. Vision - No.*	*Yes*	*See PEDIATRIC COVERAGE starting on page 116*	*No, pediatric dental falls under Medical. Medical and Dental do not coordinate benefits.*	*No, pediatric dental falls under Medical, and Medical and Dental do not coordinate benefits.*	*Yes, for dental - there is COB for DPPO (but not DHMO). If a member has both Pediatric dental under the medical and a buy up dental, the pediatric is primary. No COB for vision.*	*No*

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HEALTH CARE REFORM - PEDIATRIC DENTAL & VISION

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Do you send out a separate Pediatric Dental and Vision card to employee household (for those that have dependent coverage 18 and under)?	*No*	*N/A*	*No, we send one card to each covered member of the household, regardless of age. Pediatric dental and vision network logos are included on the card.*	*Dental - Yes Vision - No*	*No*	*Dental - Delta Dental will send members a separate ID card for dental benefits.* *Vision - No*	*Dental - Yes, all eligible enrolled subscribers and dependents will receive a dental ID card.* *Vision - No, a Vision Plan Information Card can be accessed online to assist in accessing care at myuhcvision.com.*	*Dental: Yes* *Vision: No*
Is the ID card under the Dependent's name?	*N/A*	*N/A*	*Yes, cards are in dependents' names.*	*Yes (for Dental only)*	*N/A*	*No, the ID card is under the Subscriber's name.*	*No, the ID card would be under the Subscriber's name*	*Yes for dental*
If the employee has dependent children 18 and under and also enrolls in the group dental program, which plan is primary?	*Pediatric Dental is Primary. Dependents under 18 will not be allowed to enroll in the Base group dental plan (D100)* *If enrolled in D200, D200 is primary.*	*N/A*	*Would need to contact Liberty Dental.*	*Pediatric Dental is Primary.*	*Pediatric Dental is Primary.*	*Pediatric Dental is Primary.*	*If the Group Dental is with UHC - Pediatric Dental is Primary.* *If the Group Dental is not with UHC - the other carrier would be primary.*	*Pediatric dental is primary.*
Is there coordination of benefits between the group dental plan and the Medical Pediatric Dental and Vision program?	*No*	*N/A*	*No*	*Only Dental and Pediatric Benefit would be primary. Not on Vision.*	*Dental - No. Pediatric dental service available in Mexico* *Vision - No.*	*Dental - Yes Vision - Yes*	*Dental - Yes. Vision - No.*	*Vision - Yes Dental - No*

HEALTH CARE REFORM - WAITING PERIODS, 1-LIFE & WRAPS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
What waiting period options will you be offering new business small groups in 2020?	*1st of the month following date of hire* *1st of the month following 30 days* *1st of the month following 60 days* *Exactly 90 days following date of hire*	*First of the Month following date of hire* *First of the Month following one month from date of hire* *First of the Month following two months from the date of hire, not to exceed 90 days** **If it exceeds 90 days, the effective date will be the first of the month following one month from the date of hire* *The employer has the option to waive the waiting period for all new hires at the initial group enrollment only*	1. *No Waiting Period: Effective first of month following date of hire (Employees hired on the 1st of the month will be effective the 1st of the following month)* 2. *30 Day Waiting Period: Effective the first of the month following 30 days from date of hire* 3. *60 Day Waiting Period: Effective 1st of the month following 60 days from the date of hire* 4. *90 Day Waiting Period: Effective on the 91st day following date of hire (This information is on the MGA)* *An employer may impose a bona fide, employment-based affiliation (orientation) period for new employees. The orientation period cannot exceed 30 days. The waiting period for new employees would begin the day after the orientation period has been completed.*	*First of the month after date of hire, first of the month after 30 days, first of the month after 60 days.*	*First of the month following: date of hire, 30 days and 60 days (NOT to exceed 90 days)*	1. *1st of month after date of hire.* 2. *1st of month after 30 days after date of hire.* 3. *1st of month after 60 days after date of hire.*	*First of the month following: date of hire, 30 days and 60 days (NOT to exceed 90 days)*	*First of the Month Following Date of Hire* *First of the Month Following 1 Month* *First of the Month Following 30 Days* *First of Month Following 60 Days*	*It is the employer's responsibility to ensure that the group does not apply a waiting period in excess of 90 days in accordance with the ACA and federal regulations.*
What procedure must a current employer follow if they want to change to a 90-day waiting period off-anniversary?	*Any WP changes can be requested at renewal.*	*A group can only make changes to their waiting period once in a 12-month period. The group must submit a letter from owner/officer on company letterhead to request the change.*	*Blue Shield does not allow off anniversary changes to the waiting period*	*No option exists within CalCPA for a 90 day waiting period. Closest option available is "first of the month after 60 days." Group should send written request to Banyan Administrators. The new hire waiting period can only be changed during Open Enrollment. N/A*	*N/A*	*90 day waiting period is not allowed. Any WP changes can be requested at renewal.*	*Call your Word & Brown representative*	*First of the Month following 60 Days is the max. All Off-Cycle Waiting Period changes are subject to UW approval.*	*Contact the Renewal Account Manager for details and process to modify waiting periods.*
When will this new 90-day waiting period become effective?	*Any WP changes can be requested at renewal.*	*The new 90-day waiting period will take effect the first of the month following receipt of the letter.*				*N/A*		*No 90-day waiting period will be implemented. New 60 Day max limit will be implemented upon Group renewal.*	*First of the month following request*
Any special criteria for eligible 1-life groups (under AB1083 law)?	*Aetna will require a W-2 employee who is not the owner or owner's spouse to be enrolled for all groups.*	*A sole proprietorship is ineligible for enrollment without a common law employee. An owner/spouse/ domestic partner does not constitute a common law employee.*	*Blue Shield does not write owner-only groups. There must be one full-time common law non-owner/ non-officer employee.*	*No one-person groups can be written through Word and Brown.*	*Call your Word & Brown representative*	*W-2 employee must be enrolled for all groups. A sole proprietorship is ineligible for enrollment without a common law employee. An owner/spouse/ domestic partner does not constitute a common law employee.*	*Call your Word & Brown representative*	*1-life groups must meet the same criteria as any other group. The 1-life must be a W-2 employee that's not an owner or spouse of the owner, that works in CA, and has been working 20 or 30 hours for 50% of the prior calendar quarter or prior calendar year.*	*An owner-only group with no common law employees is ineligible for small business coverage. The minimum requirement of one eligible employee cannot be satisfied by an individual and his or her spouse as employees when the trade or business is wholly-owned by the individual or by the individual and his or spouse. A minimum of one w-2 employee enrolls.*
Wrap with Kaiser Permanente or any other carrier in 2020?	*Groups offering other carrier's HMO must have at least 25 percent participation and a minimum of five employees enrolling in an Aetna plan.*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Call your Word & Brown representative*	*Yes*	*Yes—for HMO plans only. 70% of group's eligible employee population should be covered by a group health care plan. If a group chooses a PPO, they cannot have another carrier written alongside.*
If "yes," any plan limitations?	*Employees covered by the same employer on another group policy are not considered a valid waiver.*	*Group must meet participation requirements*	*Blue Shield will allow it be written alongside any other carrier's HMO plan in our Off-Exchange portfolio only. Participation guidelines apply.*	*Must be a group Kaiser plan*				*Group must meet Health Net participation first, then they can cover the rest under any carrier. No plan limitations.*	

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HEALTH CARE REFORM - WAITING PERIODS, 1-LIFE & WRAPS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
What waiting period options will you be offering new business small groups in 2020?	*MediExcel does not require a waiting period. Employer shall determine waiting period for new hires, rehires and other eligible employees, which shall not exceed the waiting period permitted by applicable state or federal law.*	*0, 30, 60 and 90 days.*	*First of the month following date of hire; First of the month following one month from date of hire; First of the month following two months from the date of hire, not to exceed 90 days*	*Sharp Health Plan does not require a waiting period. Employer shall determine waiting period for new hires, rehires and other eligible employees, which shall not exceed the waiting period permitted by applicable state or federal law.*	*First of the month following 30, 60 or 90 days.*	*SHP does not require a waiting period. Employer shall determine waiting period for new hires, rehires, and other eligible employees, which shall not exceed the waiting period permitted by applicable state or federal law.*	*First of the Month Following Date of Hire (or 0 days)* *First of the Month Following 30 days (or 1 month)* *First of the Month Following 60 days (or 2 months)*	*First of the month following Date of Hire* *First of the month following 30 days from Date of Hire* *First of the month following 60 days from Date of Hire*
What procedure must a current employer follow if they want to change to a 90-day waiting period off-anniversary?	*N/A*	*Submit a coverage change request to underwriting. Assuming underwriting approved, the change will go into effect on the first of the following month.*	*Oscar only allows updates to waiting period at renewal.*	*N/A*	*We will require a written notice with the request.*	*N/A*	*Only the 3 waiting periods above are available. Contact the Renewal Account Consultant for details & process to modify waiting periods.*	*WHA groups have a maximum of 1st of the month following 60 days from Date of Hire.*
When will this new 90-day waiting period become effective?	*N/A*				*First of the month following request*	*N/A*		*N/A*
Any special criteria for eligible 1-life groups (under AB1083 law)?	*A minimum of one common law employee is required. Owner and their spouse alone or together cannot enroll.*	*They are ineligible*	*1-life groups must submit 100% ownership docs, and the owner and/or their spouse cannot enroll alone or together without another employee.*	*An owner/officer only group with no common law employees is ineligible for small business coverage. A minimum of one eligible employee is required that is not an officer/owner or spouse of an officer or owner.*	*N/A*	*An employer with only an owner and partner or with only an owner and spouse is not eligible. A minimum of one eligible common law employee is required to be considered eligible.*	*N/A*	*An owner/officer only group with no common law employees is ineligible for small business coverage. A minimum of one eligible employee is required that is not an officer/owner or spouse of an officer or owner.*
Wrap with Kaiser Permanente or any other carrier in 2020?	*Yes*	*No*	*Yes, will wrap with any other carrier*	*Yes*	*Yes with Kaiser - cannot be sold with another Cross Border option Plan*	*Yes*	*Yes—wrapping permitted only with recognized Staff Model carriers. No plan limitations. Groups offering UnitedHealthcare and a staff model: Choice Simplified Package There must be at least 60% participation between the two carriers with 5 California employees enrolling with UnitedHealthcare, excluding COBRA participants.* A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/waivers from any employees not reflected on the billing statement. Multi-Choice State Package There must be at least 60% participation with UnitedHealthcare, excluding COBRA participants. A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/waivers from any employees not reflected in the billing statement.*	*Yes*
If "yes," any plan limitations?	*Minimum of 1 EE must enroll in MEHP for Gold Plans; 3 EE's for Platinum Plans.*		*Minimum of 5 must enroll.*	*Minimum of 5 enrolled subscribers.*	*We require a total of 5 subscribers to enroll as the minimum participation.*	*SHP requires a minimum enrollment of two eligible employees, less valid waivers.*		*A minimum of 2 must enroll in WHA.*

HEALTH PLAN COMPARISON - DOCTOR SELECTION & REFERRAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
How often can members change their Primary Care Physician (PCP)?	*HMO: Anytime. Change must be requested by the 15th of the month to be effective the 1st of the following month* *MC, PPO & EPO: No PCP selection is required*	*If the request is made between the 1st-7th of the month, Anthem can retro back to the 1st of current month. If request is made after the 7th, the change will be effective on the 1st of the following month.* *For PPO plans: No PCP selection is required.*	*Participants may change anytime by contacting Member Services. Change will be effective on the 1st day of month following notice of approval. Member can also change the PCP online at: www.blueshieldca.com. They must register first.*	*A member may change as frequently as desired with a first of the month following effective date. However, if a member is in the middle of a treatment plan, say physical therapy with a Medical Group, they may not switch to a different Primary Care Physician (PCP) until the treatment plan has ended.*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 110*	*Anytime. The effective date will be the 1st day of the following month.*	*N/A*	*Once a month within PMG/IPA PMG/IPA may be changed once a month*	*Anytime - change is effective immediately*
Can family members each choose a PCP from a different IPA/Medical Group?	*Yes*	*Yes*	*HMO: Yes* *PPO: N/A*	*Yes*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 110*	*Yes, but not recommended*	*N/A*	*Yes*	*Yes:* *HMO: From Kaiser Permanente Physicians* *POS: From Private Healthcare Systems (PHCS)*
Self-referral available?	*No prior authorization or referral for OB/GYN (can be primary provider). The OB/GYN must be in the same medical group/ IPA as the PCP.*	*HMO: No prior authorization for OB/GYN.* *Other services: referral must be within the same medical group.* *PPO: Yes*	*HMO: No prior authorization or referral for OB/GYN (can be primary provider);* *Other services: if Access+ provider—yes* *All services: Specialist must be in same med. group/ IPA as PCP* *PPO: Yes*	*Available only if the medical group participates in the program. No prior authorization or referral for OB/GYN (can be primary provider)*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 110*	*No prior authorization or referral for OB/GYN (can be primary provider). The OB/GYN must be in the same medical group/ IPA as the PCP.*	*Yes*	*HMO: Yes—OB/GYN visits only (OB/ GYN must be in same medical group as PCP)* *PPO: Yes—no PCP selection required* *HSP: PCP is assigned, but members can self-refer* *CommunityCare HMO: Choose a primary care physician (PCP) contracted with the CommunityCare HP tailored network to coordinate their care.* *• Their PCP can refer to any specialist in the CommunityCare Network.* *• Care doesn't need to stay within the PCP's participating provider group (PPG).*	*No prior authorization or referral for OB/GYN (can be primary provider)* *Other Specialties: Yes—to certain specialties. Self-refer specialties list varies by geographical region*
Express referral available?	*No—see self-referral information above*	*No*	*No—see self-referral information above*	*Available only if the medical group participates in the program*	*Varies by Health plan. See PROVIDER INFORMATION starting on page 110*	*No*	*No*	*Yes—if a Rapid Access Provider*	*Yes - referral direct from physician*

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HEALTH PLAN COMPARISON - DOCTOR SELECTION & REFERRAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
How often can members change their Primary Care Physician (PCP)?	*Anytime - change is effective immediately*	*Unlimited*	*N/A - All plans are EPOs with no PCP requirement*	*Anytime - change is effective 1st of the following month*	*Members are not assigned to a PCP provider*	*Anytime – change is effective 1st of the following month.*	*HMO: As often as necessary (submit change request on or before the 15th in order to be effective the 1st of the following month)* *PPO: N/A*	*Once a month - changes are effective the first of the following month, provided the member is not in the course of treatment or hospitalized and no pending authorizations*
Can family members each choose a PCP from a different IPA/Medical Group?	*No*	*Yes*	*N/A - All plans are EPOs with no PCP requirement*	*Yes*	*Members are not assigned to a PCP provider.*	*Yes*	*HMO: Yes* *PPO: N/A*	*Yes*
Self-referral available?	*Yes - for OB/GYN visits*	*Yes*	*N/A - All plans are EPOs with no referral requirement*	*Yes - for OB/GYN visits if OB/GYN is in same IPA as PCP.*	*Yes, OBGYN only*	*Yes, self-referral is available for health coaching, behavioral health services, and OB/GYN services.*	*HMO: Yes - for OB/GYN visits (OB/GYN must be in the same medical group/ IPA as your PCP)* *PPO: N/A*	*Yes – only for OB/GYN, annual eye exam, and behavioral health services*
Express referral available?	*Yes, direct from PCP Provider.*	*No referrals are required to see a specialist.*	*N/A - All plans are EPOs with no referral requirement*	*Yes - if available through medical group.*	*PCP provider will provide an express referral.*	*N/A*	*HMO: Yes - if an Express Referrals™ participating medical group. See Provider Directory or www.uhcwest.com for list of participating medical groups.* *PPO: Yes*	*N/A*

HEALTH PLAN COMPARISON - HSAs, HRAs & OUT-OF-NETWORK

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Do any of your HSA-Compatible or HRA-Compatible High Deductible Health Plans (HDHP) have an embedded† deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible?	*Yes, all plans are based on embedded deductible*	*Yes*	*Yes*	*Yes* *All CalCPA Health HSA plans have an embedded deductible.*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
On plans which include out-of-network benefits, what do you use to determine benefit [Limited Fee Schedule (LFS), Usual, Customary & Reasonable (UCR), percentage of Medicare, etc.]?	*Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out of-network health care providers is 100 percent of the rate that Medicare pays them.*	*Anthem's allowable amount (proprietary fee schedule).*	*Blue Shield's Allowable Amount (LFS)*	*LFS for all plans except the Protect 10 plan, which is UCR*	*HMO: N/A* *PPO: Negotiated Fee*	*N/A*	*Varies*	*MAA Maximum Allowable Amounts*	*HMO: N/A* *POS & PPO: UCR*

† *When HSA plans were first introduced in 2004, IRS publications used the term "embedded deductible" to refer to the individual deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible. Current IRS publications do not use the term "embedded deductible."*

IRS Publication 969 (2010) "Health Savings Accounts and Other Tax-Favored Health Plans" provides the following HDHP eligibility clarification on page 4:

*"**Family plans that do not meet the high deductible rules.** There are some family plans that have deductibles for both the family as a whole and for individual family members. Under these plans, if you meet the individual deductible for one family member, you do not have to meet the higher annual deductible amount for the family. If either the deductible for the family as a whole or the deductible for an individual family member is below the minimum annual deductible for family coverage, the plan does not qualify as an HDHP."*

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HEALTH PLAN COMPARISON - HSAs, HRAs & OUT-OF-NETWORK

	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Do any of your HSA-Compatible or HRA-Compatible High Deductible Health Plans (HDHP) have an embedded† deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible?	*Yes*	*N/A*	*Yes*	*Yes*	*Yes*	*N/A*	*Yes*	*No*	*Yes*
On plans which include out-of-network benefits, what do you use to determine benefit [Limited Fee Schedule (LFS), Usual, Customary & Reasonable (UCR), percentage of Medicare, etc.]?	*HMO: N/A* *POS & PPO: UCR*	*Out of network claims are paid based on usual and customary charges.*	*Out of network benefits are calculated using a percentage of Medicare. If the service isn't listed, then UCR is utilized.*	*None of our plans cover out-of-network benefits except in case of emergency. Oscar bases rates for covered OON emergency services based on the greater of the median negotiated rate in a region and the Medicare rate.*	*Please contact your Word & Brown representative*	*Out of network claims are paid based on usual and customary charges.*	*SHP does not offer out-of-network benefits except for emergency or urgent care treatment. Benefits for emergency or urgent care services are calculated at billed charges. SHP does not use a specific fee schedule or UCR rate.*	*HMO: N/A* *PPO: Reimbursement for *Non-Network treatment is based on percentage (110%) of the published rates allowed by Medicare for the same or similar services*	*HMO: N/A*

† *When HSA plans were first introduced in 2004, IRS publications used the term "embedded deductible" to refer to the individual deductible within a family plan in which an individual family member does not have to meet the higher family deductible if he/she has met the lower individual deductible. Current IRS publications do not use the term "embedded deductible."*

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HEALTH PLAN COMPARISON - HOUSE CALLS, TELEMEDICINE
& OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Doctor House Calls available through Heal™ or another provider of this type of service?	HMO plans: No PPO plans: Yes	HMO plans: No PPO plans: Yes	As of 1/1/2020: TRIO HMO: Yes Access + HMO: No Local Access + HMO: No Full PPO/Tandem PPO: Yes	HMO plans: No PPO plans: No	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: No	HMO plans: Dependent on carrier PPO plans: Dependent on carrier	HMO plans: Urgent care only PPO plans: Yes	HMO plans: N/A PPO plans: N/A
For more Information:	heal.com 844-644-4325 Download the Heal app. Available for Android™ and iPhone® mobile devices.	844.644.4325 (HEAL) or heal.com			Contact CaliforniaChoice customer service 800-558-8003			844-644-4325 (HEAL) or heal.com/healthnet	
Nurse's Hotline available?	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans Yes	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans Yes	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: 1-888-243-8310	HMO plans: Yes, for additional telemedicine fee PPO plans: Yes, for additional telemedicine fee	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans: Yes
For more Information:	Informed Health Line 800-556-1555	Login at anthem.com/ca			Contact CaliforniaChoice customer service 800-558-8003			24 Hour Nurse Line 800-893-5597	24/7 Care Online via KP Member Services @ 800-464-4000
Facetime/ Skype Access to Doctor?	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans: Yes Available through LiveHealth Online	HMO plans*: Yes PPO plans*: Yes ***Based on availability of physician**	HMO plans: Yes PPO plans: Yes	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	Some medical groups and physicians may offer these services via their own Patient Online Portal (POP)	HMO plans: Dependent on carrier PPO plans: Dependent on carrier	HMO plans: Yes PPO plans: Yes	HMO plans: Yes PPO plans: Yes
For more Information:	Teladoc 855-835-2362 Teladoc.com/Aetna	www. livehealthonline.com			CaliforniaChoice customer service 800-558-8003			Teladoc 855-835-2362 Teladoc.com/hn	https://mydoctor.kaiserpermanente.org/ncal/videovisit/#
Email Access to Doctor?	HMO plans: N/A PPO plans: N/A (At the discretion of the provider.)	HMO plans: No PPO plans: No	HMO plans*: Yes PPO plans*: Yes ***Based on availability of physician**	HMO plans: No PPO plans: No	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	Some medical groups and physicians may offer these services via their own Patient Online Portal (POP	HMO plans: Yes, dependent on physician PPO plans: Yes, dependent on physician	HMO plans: At the discretion of the provider PPO plans: At the discretion of the provider	HMO plans: Yes PPO plans: Yes
For more Information:					Contact CaliforniaChoice customer service 800-558-8003				Kp.org
Any other alternative health care delivery service you offer?	HMO plans: No PPO plans: No	HMO plans: Yes PPO plans: Yes Members can visit with a doctor or therapist for urgent care and behavioral health support through LiveHealth Online via phone, webcam, computer	HMO plans: Teladoc PPO plans: Teladoc	HMO plans: Yes PPO plans: Yes Members can visit with a doctor or therapist for urgent care and behavioral health support through LiveHealth Online via phone, webcam, computer	HMO plans: Varies by Health Plan EPO plans: Varies by Health Plan PPO plans: Varies by Health Plan	HMO plans: N/A	HMO plans: N/A PPO plans: N/A	HMO plans: Yes; Teladoc telehealth services and CVS Minute Clinics PPO plans: Yes; Teladoc telehealth services and CVS Minute Clinics	HMO plans: Yes PPO plans: Yes
For more Information:	N/A	www. livehealthonline.com or 844-784-8409 from 7 a.m. to 11 p.m.	N/A	www. livehealthonline.com	Contact CaliforniaChoice customer service 800-558-8003	N/A	N/A	Teladoc 855-835-2362 Teladoc.com/hn Minute Clinic minuteclinic.com	Phone appointments

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HEALTH PLAN COMPARISON - HOUSE CALLS, TELEMEDICINE
& OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Doctor House Calls available through Heal™ or another provider of this type of service?	*HMO plans: Yes, HEAL is available for all HMO plans. This service is only available for urgent care* *PPO plans: No*	*HMO plans: Varies depending on plan option* *PPO plans: Varies depending on plan option*	*EPO plans: Yes* *Doctor On Call™ hioscar.com/doctor-on-call/la*	*HMO plans: Yes* *PPO plans: Yes*	*HMO plans: No* *PPO plans: N/A*	*No*	*HMO plans: No* *PPO plans: Yes*	*No*
For more Information:		*Teladoc available*		*Phone appointments available dependent on physician - contact Sharp directly*				
Nurse's Hotline available?	*HMO plans: No* *PPO plans: No*	*HMO plans: No* *PPO plans: No*	*EPO plans: No, but each member is given access to their concierge team, which includes a nurse*	*HMO plans: Yes* *PPO plans: Yes*	*HMO plans: No* *PPO plans: N/A*	*Yes*	*HMO plans: Yes* *PPO plans: Yes*	*Yes*
For more Information:	*MediExcel has a Doctor's hotline in lieu of a nurses hotline: 619-365-4346*			*Contact Sharp directly and they will transfer you to a nurse 800-359-2002*		*Members may call the number on the back of the ID card: 855-836-3500.*	*Call the phone number on the back of the ID card to talk to an experienced registered nurse 24/7*	*877-793-3655*
Facetime/ Skype Access to Doctor?	*HMO plans: No* *PPO plans: No*	*HMO plans: Varies depending on plan option* *PPO plans: Varies depending on plan option*	*EPO plans: No*	*Varies depending on physician selected*	*HMO plans: Telehealth with SIMNSA providers available as a COVID-19 contingency* *PPO plans: N/A*	*Video Visits with advance practice clinicians are available through My Health Online. For more information visit https://www.sutterhealth.org/myhealthonline/video-visits.*	*HMO plans: Yes* *PPO plans: Yes*	*Delegated to medical group*
For more Information:		*Teladoc available*		*Please contact your Primary Care physician*			*Virtual Visits: www.uhc.com/virtualvisits*	*www.westernhealth.com/search-for-providers/virtual-visits/*
Email Access to Doctor?	*HMO plans: No* *PPO plans: No*	*HMO plans: No* *PPO plans: No*	*EPO plans: No, but text messaging available via Doctor On Call™ app*	*Varies, by physician selected*	*HMO plans: No* *PPO plans: N/A*	*Yes, if members select a provider who participates in My Health Online.*	*HMO plans: No* *PPO plans: No*	*Delegated to medical group*
For more Information:				*Please contact your Primary Care physician*				*ChooseWHA.com/connect*
Any other alternative health care delivery service you offer?	*HMO plans: No* *PPO plans: No*	*HMO plans: No* *PPO plans: No*	*EPO plans: No*	*We offer MinuteClinic through CVS*	*HMO plans: No* *PPO plans: N/A*	*No*	*HMO plans: No* *PPO plans: No*	*N/A*
For more Information:	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*		*N/A*

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Acupuncture	*Covered in accordance with ACA requirement. Refer to Plan documents for benefit detail.*	*No visit limits for HMO or PPO.*	*HMO: Covered for off exchange and mirror plans* *PPO: Covered for off exchange and mirror plans*	*PPO Plans: Acupuncture care is covered, and limited to 12 visits combined for In/ Out-of-Network per calendar year.* *HMO Plans: Acupuncture is covered when deemed medically necessary by your primary care provider.*	*See Plan Specific EOC or COI*	*Included with Medical*	*Covered*	*N/A - part of standard medical benefits. See plan summary for details.*	*Combined coverage for chiropractic and acupuncture care is included with the following plans:* **Platinum 90 HMO 0/10 + Child Dental Alt* **Gold 80 HMO 500/30 + Child Dental Alt* **Silver 70 HMO 1000/55 + Child Dental Alt* **Silver 70 HMO 1800/55 + Child Dental Alt* *Services are administered by American Specialty Health Plans of California, Inc® (ASH Plans).*
Chiropractic	*Refer to plan guide for benefit detail*	*HMO: Limited to 20 visits per calendar year.* *PPO: Limited to 20 visits per calendar year* *For more information, please see Plan Specific EOC.*	*HMO: Covered in off exchange only plans* *PPO: Covered in off exchange only plans*	*Chiropractic care is covered, and limited to 20 visits combined (participating and non-participating provider) per calendar year.*	*See Plan Specific EOC or COI*	*Not available*	*Covered*	• *Chiropractic benefits are available as a rider alongside all our HMO plans. Chiropractic is also embedded with several of our PPO and EnhancedCare PPO plans. For more information please see the plan's specific EOC.* • *X-rays and clinical laboratory tests are payable in full when provided by or referred by a contracted chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as medically necessary and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.* *What's not covered* *Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of your plan. Consult your plan's Evidence of Coverage for more information.*	*Combined coverage for chiropractic and acupuncture care is included with the following plans:* **Platinum 90 HMO 0/10 + Child Dental Alt* **Gold 80 HMO 500/30 + Child Dental Alt* **Silver 70 HMO 1000/55 + Child Dental Alt* **Silver 70 HMO 1800/55 + Child Dental Alt* *Services are administered by American Specialty Health Plans of California, Inc® (ASH Plans).*
Dental-Adult	*Available*	*Available*	*Available*	*N/A*	*Discount or Buy-up (available to all dependents)*	*Available*	*Available*	*Optional Health Net Dental & Vision plans available - call representative for details*	*Available*
Dental-Pediatric **Included in rates?**	*Yes* *Yes*	*Yes - Pediatric dental is embedded within all medical plans.*	*Yes - automatically embedded with medical* *Yes*	*Yes* *Yes*	*Yes* *Yes*	*Yes* *Yes*	*Not Covered*	*Yes (Not covered in SIMNSA)*	*Yes* *Yes*
Hearing Treatment	*Hearing exams are covered in accordance with ACA requirements as an essential health benefit.*	*Routine hearing tests covered; refer to EOC for details.*	*Routine hearing tests are covered in accordance with ACA requirements. Refer to preventive care guidelines.*	*Not covered - routine hearing tests, except as specifically provided under "Preventive Care" benefits of medical care that is covered (Beneficiaries age 7 and older).*	*See Plan Specific EOC or COI*	*Routine hearing test covered; refer to EOC for details.*	*Not Covered*	*HMO: Routine hearing screening in PCP's office—office visit copay* *PPO: Routine hearing exam - Office visit co-pay*	*HMO & PPO: Coverage includes medical examinations of the ear and audiometric examination to measure hearing acuity.*
Hearing Aids Covered?	*Hearing Aids are not covered.*	*No*	*Blue Shield offers a hearing aid discount program through our Wellness offering through EPIC Hearing.*	*No*	*See Plan Specific EOC or COI*	*No*	*Not Covered*	*No*	*No*

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HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Acupuncture	*Not covered*	*Not covered*	*Oscar covers acupuncture as medically necessary if Members meeting the criteria outlined in our Acupuncture Clinical Guideline*	*Covered benefit - please see member handbook for details. Additional Acupuncture riders available for purchase.*	*Covered after applicable copayment.*	*Acupuncture is a standard benefit and is embedded into all HMO Plans. Enhanced acupuncture benefits are also available through purchase of an optional rider.*	*Acupuncture is a standard benefit and is embedded into all HMO and PPO plans.* *HMO:* *$10 copayment* *PPO:* *See plan summary for benefit details*	*Traditional and deductible plans:* *Covered with $15 copayment and contributes to OOPM* *HDHPs:* *Covered in full after deductible*
Chiropractic	*Not covered*	*Covered under outpatient physical medicine which has a limit of 30 visits per plan year.*	*Coverage Exclusion*	*Chiro riders available for purchase.*	*Not covered*	*Yes, chiropractic coverage is available as an optional benefit. It is not available with high-deductible plans.*	*Chiropractic is a standard benefit and is embedded into most HMO and all PPO plans* *HMO:* *$15 per visit with a 20 visit max (except Multi-Choice State Package HMO plans, this benefit is excluded and no rider option available)* *PPO:* *Manipulative Treatments (Chiro) are included in all PPO plans; benefits are limited to 24 visits per year, see plan summary for benefit details.*	*Traditional and deductible plans:* *Covered with $15 copayment, up to 20 visits per year* *HDHPs:* *Covered in full after deductible*
Dental-Adult	*Available*	*Not covered*	*Dental care for Members age nineteen (19) and older is a coverage exclusion.*	*Not covered*	*Available as a Rider Only*	*Yes, adult dental coverage is an optional benefit available to purchase.*	*Available*	*Available as a rider only*
Dental-Pediatric **Included in rates?**	*Included in all small group plans* *Yes*	*For the wellness visits covered under ACA, they are included in the rates.*	*Covered.* *Yes, included in medical plan premium rate*	*Yes - embedded into base medical plan* *Yes*	*Included in all small group plans*	*Pediatric dental benefits are embedded for members age 19 and under.*	*Yes - embedded into base medical pan* *Yes*	*Yes* *Yes*
Hearing Treatment	*Routine hearing exam*	*No*	*No*	*Hearing Exams in PCP office as part of a physical exam.*	*Yes, any services that are medically necessary would be covered.*	*SHP covers preventive hearing exams and medically necessary services.*	*Contact your Word & Brown representative*	*Routine hearing exam* *Office visit co-pay*
Hearing Aids Covered?	*No*	*No*	*No*	*Not covered*	*No*	*No*	*Yes - contact your Word & Brown representative for more details.*	*No*

HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Infertility	*All plans: Covered services for the diagnosis and treatment to determine the cause of infertility and treat underlying medical condition.* *See Plan Specific EOC or Plan Design and Benefits for complete details on coverage, exclusions and maximum allowable amounts.*	*Covered services include diagnostic testing to determine the cause of infertility and treat underlying medical conditions.* *Optional Rider plans available.*	*HMO/PPO: Not covered. Rider available*	*Covered: California regulations require limited infertility coverage to be offered, at an additional premium cost. If you would like information on this coverage please contact Banyan Administrators within 30 days of the employer effective date.*	*See Plan Specific EOC or COI*	*Not covered. Rider available.*	*Benefits are included for procedures which are consistent with established medical practices in the treatment of infertility by a Physician. These procedures include, but are not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer. Benefits will not be available for in-vitro fertilization procedures.*	*Optional rider available for infertility benefits. Please see the Evidence of Coverage (EOC) or Certificate of Insurance (COI) for complete details on coverage and exclusions.*	*The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.* *If infertility is offered, all plans must have infertility and a plan without infertility cannot be offered.* *PPO plan designs include infertility and cannot be purchased without infertility. PPO plan can be offered with a HMO that does not have infertility.*
Life	*No*	*Available*	*Available*	*N/A*	*Available*	*No*	*Covered*	*Available*	*Not Available*
Speech Therapy	*Covered as outlined in Plan Documents.*	*Covered as outlined in the Schedule of Benefits or Evidence of Coverage.*	*Covered as outlined in the Schedule of Benefits and Evidence of Coverage.*	*Yes - outpatient speech therapy following injury or organic disease.*	*See Plan Specific EOC or COI*	*Covered as outlined in the Schedule of Benefits or Evidence of Coverage*	*Covered*	*HMO: Office visit copay - provided as long as significant improvement is expected.* *PPO: Applicable copay/ coinsurance applies*	*HMO & PPO: Covered if deemed medically necessary by Health Plan physician.*

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HEALTH PLAN COMPARISON - OPTIONAL BENEFITS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Infertility	*Covered benefit, please see EOC for details on coverage.*	*Yes, for groups with 50 or more employees, fertility is covered up to a maximum of $10k per plan year.*	*Oscar covers basic infertility services when medically necessary. If Member enrolls in an INF plan.*	*If a 20+ group, optional riders available for ART (Assisted Reproductive Technologies) —call your Word & Brown representative for details.*	*Please refer to EOC for details on coverage*	*SHP offers small group "Plus" plan designs that include embedded infertility benefits.*	*HMO: Optional benefit is available. Infertility Rider rate is calculated at a 4.8% premium increase. PPO: Services to treat or correct underlying causes of infertility are covered. Benefits are limited to $2,000 per covered person during the entire period of time he or she is enrolled for coverage under the policy. Pre-service notification is required. See Certificate of Coverage for details.* ***Infertility is excluded from Multi-Choice State Select package plans*	*Optional rider to Employers with 20+ eligible Employees*
Life	*No*	*N/A*	*Coverage Exclusion*	*Not Available*	*Not Available*	*N/A*	*Available*	*N/A*
Speech Therapy	*Covered benefit, please see EOC for details on coverage.*	*Covered under outpatient physical medicine which has a limit of 30 visits per plan year.*	*Covered Benefit. Please see SBC for benefit limits.*	*Covered benefit, please see summary of benefits and member handbook for details on coverage.*	*Covered Benefit. Please see SBC for details.*	*SHP covers medically necessary speech therapy services.*	*Speech Therapy is a standard benefit and is embedded into all HMO and PPO plans* *HMO: No visit limitation; copay varies by plan.* *PPO: No visit limitation. Copayment/ Coinsurance varies by plan.*	*HMO: Covered when medically necessary*

NOTE: Unless otherwise noted, information shown on this page reflects in-network benefits.

HEALTH PLAN COMPARISON - PRESCRIPTIONS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
If generic available, and doctor has not indicated "dispense as written," will member receive a generic equivalent rather than a brand name drug?	*Yes—if the member requests a name brand, they will pay the applicable copayment, plus the difference between the generic and brand name price.*	*If the member doesn't present a script with dispense as written (DAW) included but still prefers the brand, they can get the brand drug in that case, too, and the member pays the generic copay plus the cost difference between the generic and the brand cost. If the member doesn't have a script with dispense as written noted in it, and does NOT prefer the brand, they'll receive the generic, if available.*	*Yes—or member must pay generic copay plus difference between cost of generic and brand name drug*	*Yes*	*See PRESCRIPTIONS starting on page 110*	*Yes - Generic unless specified*	*No*	*Yes—member will receive generic unless brand is requested. If brand is requested by member, the member will pay the brand copay plus the difference in cost between the brand and generic*	*HMO: Yes* *POS: Yes*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay amount?	*No—if the member requests a name brand, they will pay the applicable copayment, plus the difference between the generic and brand name price.*	*Yes, but only if this is a brand drug with no generic equivalent. If there is a generic equivalent, and a DAW prescription is presented, the scenario described directly above applies.*	*No, the member is responsible for the difference in cost between the brand and generic, in addition to the generic drug copayment*	*No, generic substitution is mandatory. The doctor must obtain authorization through a clinical review. Otherwise, the member will be responsible for the difference in price between the generic and brand.*	*See PRESCRIPTIONS starting on page 110*	*No - member is responsible for the difference in cost between the brand and generic, in addition to the generic drug copayment*	*Yes*	*Varies by plan. Members should refer to EOC/ Certificate for specific information*	*HMO: Yes* *POS: Yes—if brand name is on Health Plan Formulary*
Does carrier use Rx formulary?	*Yes*	*Non-formulary drugs are not covered.*	*Yes—for all plans*	*Yes*	*See PRESCRIPTIONS starting on page 110*	*Yes*	*Yes*	*Yes - Health Net refers to their Formulary. Members should refer to EOC for copayment.*	*HMO: Yes* *POS: Yes*
Are non-formulary drugs available?	*No*	*Non-formulary drugs are not covered.* *Please note: Usually non-formulary drugs can still be obtained/covered via the prior auth process if the drug is deemed to be clinically appropriate.*	*All HMO Plans: Yes* *All PPO Plans: Yes* *All HSA Plans: Yes*	*Yes*	*See PRESCRIPTIONS starting on page 110*	*Non-formulary not covered unless exception request is processed and approved*	*Yes*	*Member should refer to EOC for copayment information.*	*HMO: Yes—if deemed medically necessary by Plan Physician* *POS: Yes—$40 non-formulary copay applies. Select prescription medications are excluded from out-of-network coverage*
Mail Order	*HMO & PPO plans: 2X retail copay - 31 day up to 90 day supply available*	*Please see plan specific EOC.*	*All plans*	*Yes—using Prescription Drug Program*	*See MAIL ORDER starting on page 112*	*Yes*	*Yes*	*Member should refer to EOC for copayment information.*	*Prescriptions plans that have up to a 30-day supply: 1 copay for up to a 30-day supply or 2 copays for a 31-to 100-day supply Prescriptions plans that have up to a 100-day supply: 1 copay for up to 100 supply (mail order or pharmacy) (plus Brand name deductible where applicable)*

Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

HEALTH PLAN COMPARISON - PRESCRIPTIONS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
If generic available, and doctor has not indicated "dispense as written," will member receive a generic equivalent rather than a brand name drug?	*N/A*	*Yes*	*Yes*	*Yes—or member must pay non-formulary copay*	*N/A*	*Yes*	*Managed or Closed Formulary Plans: Yes* *Open Formulary Plans: Yes*	*Yes—or you must pay the brand copay plus the difference in cost between the brand name and generic equivalent*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay amount?	*Yes*	*Regardless of whether the doctor or the patient requests the brand when there is a generic equivalent, the patient will receive the generic. If the doctor or patient wants the brand when a generic equivalent is available, they can do so but the customer will pay the brand name copay (if the plan chosen has an Rx copay) PLUS the different between the brand and generic cost.*	*If provider checks DAW prescription, Member gets Rx at the tiered copay the brand and generic cost.*	*Yes*	*N/A*	*Yes, the member will receive the brand drug with the cost share of the generic copay plus the cost difference between the brand and generic.*	*No*	*Yes*
Does carrier use Rx formulary?	*Yes*	*Yes*	*Yes*	*Yes*	*N/A*	*Yes*	*Yes*	*Yes, a preferred drug list*
Are non-formulary drugs available?	*Yes—non-formulary copay applies*	*Any drug not listed on the formulary is excluded and not covered.*	*We only cover non-formulary drugs if they are determined to be medically necessary for a particular member. Members can have their provider apply for a Non-Formulary Exception to Caremark to prove medical necessity.*	*Yes—non-formulary copay applies*	*N/A*	*Yes, if medically necessary and the member has tried and failed preferred alternatives.*	*Yes, if medically necessary and the member has tried and failed preferred alternatives.*	*Yes, covered as Tier 3 Non-preferred medication*
Mail Order	*Mail Order Service is not available*	*90 day supply*	*90 day supply*	*Yes—medication needs to be on maintenance list.*	*N/A*	*Mail order is available up to a 100-day supply of their maintenance prescription drugs for the cost of two retails copays.*	*HMO: Yes—2X retail copay* *PPO: Yes—2.5X retail copay*	*90 day supply for mail order or at Walgreens or CVS (Smart90 program)*

Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Use Employer or Employee ZIP Code?	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Employee ZIP Code*	*Call your Word & Brown representative*	*Employer ZIP Code*	*Employee*	*Employer ZIP Code*	*Employer ZIP Code*
How are out-of-state employees rated?	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Employer ZIP Code*	*Call your Word & Brown representative*	*Employer ZIP Code*	*New Hire rates will be based on the member's age at the member's enrollment date*	*Employer's physical address in CA*	*N/A*
DE-9C statement required?	*2-5 & virgin groups: Yes* *Groups 6+: DE-9C, Prior Carrier Bill, and Proof of Eligibility Form – not required* **Tax documents may be requested at the discretion of the underwriter.*	*Not required for ancillary lines.*	*Yes—and it must be unaltered. If any alterations special requirements apply. Call your Word & Brown representative for details.*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes—must also submit payroll records for employees hired after DE-9C filing*
Payroll records OK if no DE-9C?	*Call your Word & Brown representative*	*Anthem may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.*	*Call your Word & Brown representative*	*Yes*	*Call your Word & Brown representative*	*Yes - minimum 6 weeks*	*Yes*	*Yes—4 weeks of payroll is sufficient for groups of 6+ enrolling. Less than that requires payroll showing they've been in business for 50% of the prior calendar quarter. Prior bills are required for employer paid dental rates, COBRA enrollment, and certain LOA situations.*	*No*
Is a prior booklet required?	*No* *May be requested at the discretion of the underwriter.*	*No*	*No*	*No*	*Yes—only if any employees take PPO Dental*	*No*	*No*	*No*	*No*
Is prior billing required?	*No* *May be requested at the discretion of the underwriter.*	*Call your Word & Brown representative*	*Yes for prior carrier deductible credit*	*Call your Word & Brown representative*	*Call your Word & Brown representative*	*May be requested at the discretion of the underwriter*	*No*	*Call your Word & Brown representative*	*Call your Word & Brown representative*

† *Payroll records must include the number of hours worked for each employee. If no DE-9C, group must also submit copy of their business license and tax ID number. Group must be in business a minimum of 50% of prior quarter in order to be guaranteed issue.*

* *Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.*

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Use Employer or Employee ZIP Code?	*Employer ZIP Code*	*Employer*	*Employer*	*Employer ZIP Code*	*Employer ZIP Code*	*Rates are based the ZIP code for the employer's headquarters or location within SHP's licensed service area.*	*Employer ZIP Code*	*Employer ZIP Code*
How are out-of-state employees rated?	*Out of State employees not eligible, unless employee reports to worksite in San Diego County or Imperial County.*	*It is a blended rate*	*N/A*	*N/A*	*Not covered, employee is required to work out of San Diego or Imperial County to be covered.*	*Rates are based the ZIP code for the employer's headquarters or location within SHP's licensed service area.*	*Employer ZIP Code*	*N/A*
DE-9C statement required?	*Yes*	*Yes, we do require a quarterly contribution/wage report for each employer from their respective state(s).*	*Yes*	*Yes*	*Yes*	*Reconciled DE-9C is required for one to five eligible employees and any group size for sole proprietor and partners. Completed New Employee Verification Form is required for employees not listed on the DE-9C* *SHP Underwriting reserves the right to request a DE-9C.*	*Employers with 1-9 eligible employees: Yes, a copy of the most recent quarterly DE-9 and DE-9C with all employees listed (including all pages).* *Employers with 10+ Eligible employees: No, a completed and signed UHC Participation Certification form can be submitted in lieu of DE-9C.*	*Yes*
Payroll records OK if no DE-9C?	*Yes*	*If none filed, yes and may require additional documents.*	*Yes*	*Yes—require minimum of six weeks*	*Yes, require minimum of four weeks*	*Yes, along with a completed New Employee Verification Form, except for sole proprietors or partnerships. Sole proprietors and partnerships must provide reconciled DE-9C only and are not allowed to use the employee verification form.*	*See note above*	*Yes—if DE-9C not filed yet, minimum 2 payroll records required (and DE-9C when available)*
Is a prior booklet required?	*No*	*No*	*No*	*No*	*No*	*No*	*No*	*No*
Is prior billing required?	*No*	*Yes*	*No*	*No—but underwriter may require upon request.*	*No*	*No, but the employer may provide prior carrier premium invoice in lieu of reconciled DE-9C. Completed new Employee Verification Form is required for employees not listed on the current premium invoice.*	*For Dental only*	*No - may be provided in lieu of DE9C*

HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Must submit check with initial application?	*ACH debit form is preferred method of premium payment.*	*Yes*	*Yes or initial payment form with copy of voided check*	*No*	*Yes*	*Yes*	*No*	*Yes - minimum 75% of the 1st month's premium.*	*No—but they do need a copy of check*
Make check payable to	*Aetna Health of California, Inc.*	*Anthem Blue Cross*	*Blue Shield of California*	*Check not required with submission*	*CaliforniaChoice®*	*Chinese Community Health Plan*	*E.D.I.S.*	*Health Net*	*Kaiser Permanente*
New in Business Minimum length of time in business?	*Six weeks prior to the effective date and meet all other requirements of a Small Employer*	*Start up company form is required*	*Start up attestation and form W4 or one pay cycle required*	*No minimum required*	*Call your Word & Brown representative*	*Six weeks prior to the effective date and meet all other requirements of a Small Employer.*	*No*	*Groups enrolling 2-5: Half the prior calendar quarter* *Groups 6-100: 4 weeks prior to effective date.*	*50% of previous calendar quarter. If proves less, Kaiser Permanente will recertify the group upon the first renewal*
Payroll records† required? If yes, how long?	*6+ enrolled, no payroll or prior carrier bill is required.* **subject to UW discretion*	*Start-up companies must provide the first 30 days of payroll records for all employees within 45 days of the effective date.*	*Yes—Call your Word & Brown representative*	*No—except when spouse is enrolled as an employee Or when DE9C is not yet available.*	*A minimum of 1 run or from start date to current, whichever is greater.*	*Yes* *DE-9C or 4 weeks of payroll are required.*	*6 weeks*	*DE-9C required unless not in business long enough to have one. Then 4 weeks of payroll is sufficient for groups of 6+ enrolling. Less than that requires payroll showing they've been in business for 50% of the prior calendar quarter. Prior bills are required for employer paid dental rates, COBRA enrollment, and certain LOA situations.*	*Varies depending on when the business was established but 1 month may be acceptable*
Copy of business license?	*Refer to other documents required*	*Yes*	*Call your Word & Brown representative*	*No*	*Call your Word & Brown representative*	*Yes*	*No*	*Acceptable ownership documentation varies by business structure—call Word & Brown rep*	*Yes*
Other documents required?	*Call your Word & Brown representative*	*Depending on the type of organization, other documents may be required. Please refer to the Underwriting Guidelines.*	*Call your Word & Brown representative*	*Subscription Agreement with CalCPA membership number, or if not, currently a photocopy of Society membership application and proof of payment of dues.*	*Call your Word & Brown representative*	*Please refer to the New Group Submission Checklist.*	*Call your Word & Brown representative*	*Acceptable ownership documentation varies by business structure—call your Word & Brown representative*	*New group application, employee applications, declination of coverage, and proprietor/ partner/ corporate officer form*

† *Payroll records must include the number of hours worked for each employee. If no DE-9C, group must also submit copy of their business license and tax ID number. Group must be in business a minimum of 50% of prior quarter in order to be guaranteed issue.*

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HEALTH PLAN COMPARISON - RATES & DOCUMENTS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Must submit check with initial application?	*Yes*	*Yes, but if electing autopay, no check is needed*	*No*	*ACH form can be submitted in lieu of check*	*Yes*	*Yes*	*Yes*	*Yes, if paying via Echeck no check is required*
Make check payable to	*MediExcel Health Plan*	*National General Insurance*	*Oscar Health Plan of California*	*HMO: Sharp Health Plan* *PPO: Please contact your Word & Brown rep*	*SIMNSA Health Plan*	*Sutter Health Plus*	*UnitedHealthcare*	*WHA*
New in Business Minimum length of time in business?	*4 weeks*	*No Minimum*	*4 weeks*	*45 days*	*4 weeks*	*Employer must have a minimum of 1-100 full-time equivalent eligible employees on at least 50% of its working days during the preceding calendar quarter or calendar year. Startup groups are allowed with 4 weeks of payroll and must meet all other eligibility requirements.*	*UHC will consider start-up groups that have been in business for at least 6 weeks with two weeks of payroll that support length of time in business.*	*4 weeks of payroll*
Payroll records required? If yes, how long?	*DE-9C or 4 weeks of payroll are required.*	*Yes, 60 days*	*DE 9C or 4 weeks of payroll are required.*	*Yes—6 weeks*	*DE-9C or 4 weeks of payroll are required*	*Yes, a minimum 4 weeks of payroll are required.*	*Depends on business entity—call your Word & Brown representative*	*4 weeks of payroll*
Copy of business license?	*Only if enrolling business owners are not on the DE9C*	*Only if other documentation cannot be provided.*	*Groups must submit any one of the following: Current/active business license; Fictitious Business Name statement; Statement of Information; Articles of Incorporation*	*Yes*	*No*	*Refer to SHP's Small Group Submission Broker Checklist.*	*Depends on business entity—call your Word & Brown representative*	*No*
Other documents required?	*New group application, employee applications.* *Waivers are only required when only enrollees are business owners.*	*Depending on information provided it may be possible.*	*Depends on the type of business.*	*Yes—refer to SHP website for details. Groups with less than 4 enrolled requires submission of stamped and filed SOI showing officers OR current, complete business taxes.*	*Employer and Employee Applications*	*Refer to SHP's Small Group Submission Broker Checklist.*	*Depends on business entity—call your Word & Brown representative*	*New group application, employee applications, declination of coverage, and owner statement*

HEALTH PLAN COMPARISON - WRAP† REQUIREMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Can be written with Kaiser?	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*N/A*
Can be written with another carrier's PPO or indemnity plan?	*Group Size 1-100: Yes - standard participation of 60% must be met in order for a group to qualify for coverage. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier.*	*Yes If group is 4 or less employees, 65% participation required. If group is 5-100 employees, 25% participation required Participation in other carrier is not considered a valid waiver*	*Group Size 1-100: No If the group qualifies for the relaxed participation program, we do allow one other carrier HMO and/or PPO alongside. For off exchange portfolio only*	*Group Size 2+: Yes (with Kaiser Permanente only)*	*Group Size 1-100: No*	*Group Size 1-100: Yes*	*No*	*Group Size 1-5: Yes - may write alongside another carrier as long as HN has 66% participation. Group Size 6-100: Yes - may write alongside another carrier as long as HN has 50% participation.*	*Group Size 1-100: Yes - for HMO and POS plans only. 70% of group's eligible employee population should be covered by a group health care plan. If a group chooses a PPO, they cannot have another carrier written alongside.*
Can be written with another carrier's HMO, POS or EPO?	*Group Size 1-100: Groups offering other carrier's HMO must have at least 25% participation and a minimum of five employees enrolling in an Aetna plan. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier. (Standard participation applies alongside another carrier's POS, EPO or PPO plans.) Alongside Staff Model: Groups offering other carrier's HMO must have at least 25% participation and a minimum of five employees enrolling in an Aetna plan. Employees waiving due to coverage through spouse will NOT be considered eligible in calculating participation for a group sold alongside another carrier. (Standard participation applies alongside another carrier's POS, EPO or PPO plans.)*	*Yes If group is 4 or less employees, 65% participation required. If group is 5-100 employees, 25% participation required Participation in other carrier is not considered a valid waiver*	*Group Size 1-100: Mirror Package: No, Blue Shield must be the only carrier offered. Blue Shield Off Exchange package: Yes, 65% of total employee count must enroll and a minimum of 5 or 50% (whichever is greater) must enroll on a Blue Shield plan. Note: Blue Shield does not wrap with EPO plans.*	*Group Size 2+: Yes (with Kaiser Permanente only)*	*Group Size 1-100: No*	*Group Size 1-100: Yes*	*Yes*	*Group Size 1-5: Yes - may write alongside another carrier as long as HN has 66% participation Group Size 6-100: Yes - maybe write alongside another carrier as long as HN has 50% participation*	*Group Size 1-100: Yes - for HMO and POS plans only. 70% of group's eligible employee population should be covered by a group health care plan. If a group chooses a PPO, they cannot have another carrier written alongside.*

†Indicates flexibility in being offered with products of another carrier.

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HEALTH PLAN COMPARISON - WRAP† REQUIREMENTS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Can be written with Kaiser?	*Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Yes - minimum of 5 enrolled employees. PPO plan is not available.*	*Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*	***Groups offering UnitedHealthcare and a staff model:*** *Choice Simplified Package: There must be at least 60% participation between the two carriers with 5 California employees enrolling with UnitedHealthcare, excluding COBRA participants.* A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/ waivers from any employees not reflected on the billing statement.* *Multi-Choice State Package: There must be at least 60% participation with UnitedHealthcare, excluding COBRA participants. A complete copy of the most recent billing statement from the staff model reflecting employee census and applications/ waivers from any employees not reflected in the billing statement.*	*Yes*
Can be written with another carrier's PPO or indemnity plan?	*Group Size 1-100: Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Sharp will allow wrap with other carrier. Requires 5 enrolled subscribers on SHP.* *SHARP WILL NOT PERMIT WRAP WITH CALIFORNIACHOICE®*	*Group Size 5-100: Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*		*Group Size 1-100: Yes, a minimum of two eligible employees must enroll with WHA.*
Can be written with another carrier's HMO, POS or EPO?	*Group Size 1-100: Yes*	*Group Size 2-200: No*	*Group Size 1-100: Yes*	*Yes— Sharp requires 5 enrolled subscribers.* *SHARP WILL NOT PERMIT WRAP WITH CALIFORNIACHOICE®*	*Group Size 5-100: Yes*	*Group Size 1-100: Yes. Minimum participation requirement is enrollment of two eligible employees in an SHP medical plan, less valid waivers.*		*Group Size 1-100: Yes, a minimum of two eligible employees must enroll with WHA.*

†Indicates flexibility in being offered with products of another carrier.

Creditable Coverage Prescription drug benefit with current plan from employer is at least as good as the pharmacy benefits offered through the new Medicare Part D standard plan
Non-creditable Coverage Prescription drug benefit with current plan from employer is not as good as the pharmacy benefits offered through the new Medicare Part D standard plan

	CREDITABLE	NON-CREDITABLE
Aetna		
HMO		
CA Bronze HMO Basic $65/95 6300 Ded (2020)	■	
CA Gold HMO $25/50 250 Ded (2020)	■	
CA Gold HMO AVN $25/50 250 Ded (2020)	■	
CA Gold HMO AVN $25/50 500 Ded (2020)	■	
CA Gold HMO AWH SoCA $25/50 250 Ded (2020)	■	
CA Gold HMO AWH SoCA $25/50 500 Ded (2020)	■	
CA Gold HMO Basic $25/50 250 Ded (2020)	■	
CA Gold HMO Basic $25/50 500 Ded (2020)	■	
CA Gold HMO Ded $25/50 250 Ded (2020)	■	
CA Gold HMO Ded $25/50 500 Ded (2020)	■	
CA Platinum HMO $15/30 0 Ded (2020)	■	
CA Platinum HMO AVN $15/30 0 Ded (2020)	■	
CA Platinum HMO AWH SoCA $15/30 0 Ded (2020)	■	
CA Platinum HMO Basic $15/30 0 Ded (2020)	■	
CA Platinum HMO Ded $15/30 0 Ded (2020)	■	
CA Silver HMO AVN $50/75 6000 Ded (2020)	■	
CA Silver HMO AVN $50/85 2250 Ded (2020)	■	
CA Silver HMO AWH SoCA $50/75 6000 Ded (2020)	■	
CA Silver HMO AWH SoCA $50/85 2250 Ded (2020)	■	
CA Silver HMO Basic $50/75 6000 Ded (2020)	■	
CA Silver HMO Basic $50/85 2250 Ded (2020)	■	
CA Silver HMO Ded $50/75 6000 Ded (2020)	■	
CA Silver HMO Ded $50/85 2250 Ded (2020)	■	
CA Bronze HMO AVN $75/125 7900 Ded (2020)		■
CA Bronze HMO AWH SoCA $75/125 7900 Ded (2020)		■
CA Bronze HMO Basic $75/125 7900 Ded (2020)		■
CA Bronze HMO Ded $75/125 7900 Ded (2020)		■
PPO		
CA Gold MC 80/50 1250 Ded (2020)	■	
CA Gold MC 80/50 250 Ded (2020)	■	
CA Gold MC 80/50 750 Ded (2020)	■	
CA Gold MC AWH SoCA 80/50 1250 Ded (2020)	■	
CA Gold MC AWH SoCA 80/50 250 Ded (2020)	■	
CA Gold MC AWH SoCA 80/50 750 Ded (2020)	■	
CA Gold MC Savings Plus 80/50 1250 Ded (2020)	■	
CA Gold MC Savings Plus 80/50 250 Ded (2020)	■	
CA Gold MC Savings Plus 80/50 750 Ded (2020)	■	
CA Gold PPO 80/50 1000 Ded (2020)	■	
CA Platinum MC 90/50 0 Ded (2020)	■	
CA Platinum MC AWH SoCA 90/50 0 Ded (2020)	■	
CA Platinum MC Savings Plus 90/50 0 Ded (2020)	■	
CA Silver MC 60/50 2000 Ded (2020)	■	
CA Silver MC 60/50 4350 Ded (2020)	■	
CA Silver MC AWH SoCA 60/50 2000 Ded (2020)	■	
CA Silver MC AWH SoCA 60/50 4350 Ded (2020)	■	
CA Silver MC AWH SoCA 75/50 2800 HSA (2020)	■	
CA Silver MC AWH SoCA Copay 80/50 2250 (2020)	■	
CA Silver MC Copay 80/50 2250 Ded (2020)	■	
CA Silver MC Savings Plus 60/50 2000 Ded (2020)	■	
CA Silver MC Savings Plus 60/50 4350 Ded (2020)	■	
CA Silver MC Savings Plus Copay 80/50 2250 Ded	■	
CA Bronze MC 50/50 7300 Ded (2020)		■
CA Bronze MC AWH SoCA 50/50 7300 Ded (2020)		■
CA Bronze MC Savings Plus 50/50 7300 Ded (2020)		■
EPO		
CA Gold EPO 80 1250 Ded (2020)	■	
CA Gold EPO 80 750 Ded (2020)	■	
CA Gold EPO AWH SoCA 80 1250 Ded (2020)	■	
CA Silver EPO 60 2000 Ded (2020)	■	
CA Silver EPO 60 4350 Ded (2020)	■	
CA Silver EPO AWH SoCA 60 2000 Ded (2020)	■	
CA Silver EPO AWH SoCA 60 4350 Ded (2020)	■	
CA Bronze EPO 50 7300 Ded (2020)		■
CA Bronze EPO AWH SoCA 50 7300 Ded (2020)		■
HSA-Compatible		
CA Silver EPO 75 2800 HSA (2020)	■	
CA Silver EPO AWH SoCA 75 2800 Ded HSA (2020)	■	
CA Silver MC 75/50 2800 HSA (2020)	■	
CA Silver MC Savings Plus 75/50 2800 HSA (2020	■	
CA Brnz MC AWH SoCA 100/50 6900 Ded HSA (2020)		■
CA Bronze MC 100/50 6900 Ded HSA (2020)		■
CA Bronze MC Savings Plus 100/50 6900 Ded HSA	■	
Anthem Blue Cross		
Anthem Platinum		
Anthem Platinum PPO 15/250/10%	■	
Anthem Platinum PPO 20/10%	■	
Anthem Platinum Select PPO 15/10%	■	
Anthem Platinum Select PPO 15/250/10%	■	
Anthem Platinum Select PPO 20/10%	■	
Anthem Platinum HMO 20	■	
Anthem Platinum HMO 25	■	
Anthem Platinum Select HMO 20	■	
Anthem Platinum Select HMO 25	■	
Anthem Platinum Priority Select HMO 20	■	
Anthem Platinum Priority Select HMO 25	■	

	CREDITABLE	NON-CREDITABLE
Anthem Blue Cross (Cont.)		
Anthem Gold		
Anthem Gold PPO 20/30%	■	
Anthem Gold PPO 30/500/20%	■	
Anthem Gold PPO 30/750/20%	■	
Anthem Gold PPO 35/500/25%	■	
Anthem Gold PPO 35/1000/20%	■	
Anthem Gold Select PPO 20/30%	■	
Anthem Gold Select PPO 25/250/20%	■	
Anthem Gold Select PPO 30/500/20%	■	
Anthem Gold Select PPO 30/750/20%	■	
Anthem Gold Select PPO 35/500/25%	■	
Anthem Gold Select PPO 35/1000/20%	■	
Anthem Gold EPO 35/500/20%	■	
Anthem Gold EPO 35/1700/20%	■	
Anthem Gold HMO 30	■	
Anthem Gold HMO 35	■	
Anthem Gold Select HMO 30	■	
Anthem Gold Select HMO 35	■	
Anthem Gold Priority Select HMO 30	■	
Anthem Gold Priority Select HMO 35	■	
Anthem Silver		
Anthem Silver PPO 45/1750/40%	■	
Anthem Silver PPO 50/2000/40%	■	
Anthem Silver PPO 55/1850/35%	■	
Anthem Silver PPO 55/2500/45%	■	
Anthem Silver PPO 2000/30% w/HSA - RxC (Individual)*	■	
Anthem Silver PPO 2000/30% w/HSA - RxC (Family)	■	
Anthem Silver Select PPO 45/1750/40%	■	
Anthem Silver Select PPO 50/2000/40%	■	
Anthem Silver Select PPO 50/2250/20%	■	
Anthem Silver Select PPO 55/1850/35%	■	
Anthem Silver Select PPO 55/2500/45%	■	
Anthem Silver Select PPO 2000/30% w/HSA - RxC (Individual)	■	
Anthem Silver Select PPO 2000/30% w/HSA - RxC (Family)*	■	
Anthem Silver HMO 55	■	
Anthem Silver HMO 55/2250/45%	■	
Anthem Silver Select HMO 55	■	
Anthem Silver Select HMO 55/2250/45%	■	
Anthem Silver Priority Select HMO 55		
Anthem Silver Priority Select HMO 55/2250/45%		
Anthem Bronze		
Anthem Bronze PPO 40/5600/40%		■
Anthem Bronze PPO 60/6350/40%	■	
Anthem Bronze PPO 70/6300/35%		■
Anthem Bronze PPO 3950/50%		■
Anthem Bronze PPO 5000/45% w/HSA		■
Anthem Bronze PPO 6600/0% w/HSA		■
Anthem Bronze Select PPO 40/5600/40%		■
Anthem Bronze Select PPO 60/6350/40%	■	
Anthem Bronze Select PPO 70/6300/35%		■
Anthem Bronze Select PPO 3950/50%		■
Anthem Bronze Select PPO 5000/45% w/HSA		■
Anthem Bronze Select PPO 6600/0% w/HSA		■
Anthem Bronze Select PPO 6900/0% w/HSA		■
Blue Shield of California		
Off Exchange Package for Small Business		
Off-Exchange HMO Plans†		
Platinum HMO 0/20	■	
Platinum HMO 0/25	■	
Platinum HMO 0/30	■	
Gold HMO 0/30	■	
Gold HMO 500/35	■	
Gold HMO 1000/30	■	
Gold HMO 1500/35	■	
Silver HMO 2350/65	■	
Off-Exchange PPO Plans††		
Platinum PPO 0/0	■	
Platinum PPO 0/10	■	
Platinum PPO 250/15	■	
Gold PPO 0/20	■	
Gold PPO 500/30	■	
Gold PPO 750/30	■	
Gold PPO 1200/35	■	
Silver PPO 1800/55	■	
Silver PPO 2300/45	■	
Bronze PPO 5000/70		■
Bronze PPO 6850/65		■
Bronze PPO 6500/50		■
Off-Exchange PPO Savings Plans††		
Silver PPO Savings 2000/25%	■	

(Continued)

* *These Anthem plans have a different per member deductible amount depending on whether the subscriber is enrolled as self only, or has enrolled dependents within the plan. Plans have been designed in this manner to comply with both AB1305 and IRS minimum deductible and out-of-pocket maximum requirements for embedded high deductible health plans.*

Creditable Coverage Prescription drug benefit with current plan from employer is at least as good as the pharmacy benefits offered through the new Medicare Part D standard plan
Non-creditable Coverage Prescription drug benefit with current plan from employer is not as good as the pharmacy benefits offered through the new Medicare Part D standard plan

	CREDITABLE	NON-CREDITABLE
Blue Shield of California (Cont.)		
Silver PPO Savings 2500/35%	■	
Bronze PPO Savings 5300/40%		■
Bronze PPO Savings 6900		■
Blue Shield Mirror Package for Small Business		
Blue Shield Mirror HMO Plans†		
Mirror Platinum 90 HMO 0/15	■	
Mirror Gold 80 HMO 250/25	■	
Mirror Silver 70 HMO 2250/50	■	
Blue Shield Mirror PPO Plans††		
Mirror Platinum 90 PPO 0/15	■	
Mirror Gold 80 PPO 250/25	■	
Mirror Silver 70 PPO 2250/50	■	
Mirror Bronze 60 PPO 6300/65 + Child Dental		■
†All HMO plans available on the Access+ HMO®, Local Access+ HMO®, or Trio ACO networks		
††All PPO plans available in the Full PPO network or the Tandem PPO network		
CalCPA Health		
HMO		
HMO 10/0%	■	
HMO 35/20%	■	
Select 1500	■	
Select 3000	■	
PPO		
PPO 10/0/10%	■	
PPO 20/500/20%	■	
PPO 25/550/30%	■	
PPO 25/550/30% RxV	■	
PPO 35/1200/40%	■	
PPO 40/2000/40%	■	
PPO 40/2000/40% RxV	■	
PPO 45/1500/50%	■	
PPO 45/2500/50%	■	
PPO 45/5000/10% Saver		■
PPO 65/3750/25%	■	
PPO HSA 1350/50%	■	
PPO HSA 1800/30%/RxC	■	
PPO HSA 2700/20%/RxC	■	
PPO HSA 3500/30%/RxC		■
PPO HSA 4600/20%/RxC		■
PPO HSA 5600/0%/RxC		■
CaliforniaChoice®		
HMO		
Platinum HMO A (Anthem, Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Platinum HMO B (Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Platinum HMO C (Health Net, Sharp, UnitedHealthcare)	■	
Platinum HMO D (Health Net)	■	
Platinum HMO E (Health Net)	■	
Gold HMO A (Anthem, Health Net, Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Gold HMO B (Anthem, Health Net, Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Gold HMO C (Health Net, UnitedHealthcare, Western Health)	■	
Gold HMO D (Health Net, Sharp, Western Health)	■	
Gold HMO E (Health Net)	■	
Gold HMO F (Health Net)	■	
Silver HMO A (Anthem, Health Net, Kaiser, Sharp, UnitedHealthcare, Western Health)	■	
Silver HMO B (Anthem, Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Silver HMO C (Health Net, Kaiser, Sharp, Sutter Health Plus, UnitedHealthcare, Western Health)	■	
Silver HMO D (Kaiser, UnitedHealthcare)	■	
Bronze HMO A (Health Net, Kaiser)	■	
Bronze HMO A (Sharp, Sutter Health Plus, UnitedHealthcare)		■
Bronze HMO B (UnitedHealthcare)	■	
Bronze HMO B (Sharp, Sutter Health Plus, Western Health)		■
Bronze HMO C (Kaiser)	■	
Bronze HMO C (Western Health)		■
PPO		
Gold PPO A (Anthem)	■	
Gold PPO B (Anthem)	■	
Gold PPO C (Anthem)	■	
Gold PPO D (Anthem)	■	
Gold PPO E (Anthem)	■	
Silver PPO A (Anthem)	■	
Silver PPO B (Anthem)	■	
Silver PPO C (Anthem)	■	
Bronze PPO A (Anthem)		■
Bronze PPO B (Anthem)		■
EPO		
Platinum EPO A (Oscar)	■	
Platinum EPO B (Oscar)	■	
Gold EPO A (Oscar)	■	

	CREDITABLE	NON-CREDITABLE
CaliforniaChoice® (Cont.)		
Gold EPO B (Oscar)	■	
Gold EPO C (Oscar)	■	
Gold EPO D (Oscar)	■	
Silver EPO A (Anthem, Oscar)	■	
Silver EPO B (Anthem, Oscar)	■	
Silver EPO C (Oscar)	■	
Bronze EPO A (Oscar)	■	
Bronze EPO A (Anthem)		■
Bronze EPO B (Oscar)	■	
HSA-Compatible		
Gold HMO D (Western Health)	■	
Silver EPO A (Oscar)	■	
Silver EPO B (Anthem)	■	
Silver HMO C (Sutter Health Plus, Western Health)	■	
Silver HMO D (Kaiser)	■	
Bronze EPO A (Oscar)	■	
Bronze HMO B (Sharp, Sutter Health Plus, UnitedHealthcare)		■
Bronze HMO C (Kaiser)	■	
Bronze HMO C (Western Health)		■
Chinese Community Health Plan		
HMO		
Ruby 10	■	
Ruby 20	■	
Ruby 40	■	
Opal 25	■	
Opal 50	■	
Platinum 90	■	
Gold 80	■	
Silver 70	■	
Bronze 60	■	
Bronze 60 HDHP	■	
E.D.I.S.		
Contact your Word & Brown Representative		
Health Net		
HMO		
WholeCare HMO Platinum $10	■	
WholeCare HMO Platinum $20	■	
WholeCare HMO Platinum $30	■	
WholeCare HMO Gold $30	■	
WholeCare HMO Gold $35	■	
WholeCare HMO Gold $50	■	
WholeCare HMO Silver $50	■	
CommunityCare Silver $50	■	
CommunityCare Bronze 60 HMO 6300/65	■	
Full Network HMO Platinum $10	■	
Full Network HMO Platinum $20	■	
Full Network HMO Platinum $30	■	
Full Network HMO Gold $30	■	
Full Network HMO Gold $35	■	
Full Network HMO Gold $40	■	
Full Network HMO Gold $50	■	
Full Network HMO Silver $50	■	
SmartCare HMO Platinum $10	■	
SmartCare HMO Platinum $20	■	
SmartCare HMO Platinum $30	■	
SmartCare HMO Gold $30	■	
SmartCare HMO Gold $35	■	
SmartCare HMO Gold $40	■	
SmartCare HMO Gold $50	■	
SmartCare HMO Silver $50	■	
Salud HMO y Más Platinum $10	■	
Salud HMO y Más Platinum $20	■	
Salud HMO y Mas Platinum $30	■	
Salud HMO y Más Gold $30	■	
Salud HMO y Mas Gold $35	■	
Salud HMO y Más Gold $40	■	
Salud HMO y Más Gold $50	■	
Salud HMO y Más Silver $50	■	
PureCare HSP Platinum 90 0/15	■	
PureCare HSP Gold 80 250/25	■	
PureCare HSP Silver 70 2250/50		■
PureCare HSP Bronze 60 6300/65		■
PPO		
Platinum 90 PPO 0/15	■	
Platinum 90 PPO 250/15	■	
Gold 80 PPO 0/30	■	
Gold 80 PPO 250/25	■	
Gold 80 PPO 500/20	■	
Gold 80 PPO 1000/30	■	
Gold 80 Value PPO 750/15	■	
Silver 70 PPO 2250/50	■	
Silver 70 PPO 2250/55	■	
Silver 70 Value PPO 1700/50	■	

(Continued)

MEDICARE PART D

Creditable Coverage Prescription drug benefit with current plan from employer is at least as good as the pharmacy benefits offered through the new Medicare Part D standard plan
Non-creditable Coverage Prescription drug benefit with current plan from employer is not as good as the pharmacy benefits offered through the new Medicare Part D standard plan

	CREDITABLE	NON-CREDITABLE
Health Net (Cont.)		
Silver 70 HDHP PPO 1400/40%	■	
Bronze 60 PPO 6300/65		■
Bronze 60 HDHP PPO 5600/20%		■
EnhancedCare Platinum 90 PPO 250/15	■	
EnhancedCare Gold 80 PPO 0/30	■	
EnhancedCare Gold 80 PPO 500/20	■	
EnhancedCare Gold 80 PPO 1000/30	■	
EnhancedCare Gold 80 Value PPO 750/15	■	
EnhancedCare Silver 70 PPO 2250/55	■	
EnhancedCare Silver 70 Value PPO 1700/50	■	
EnhancedCare Silver 70 HDHP PPO 1400/40%	■	
EnhancedCare Bronze 60 HDHP PPO 5600/20%		■
PureCare Platinum 90 HSP 0/15	■	
PureCare Gold 80 HSP 250/25	■	
PureCare Silver 70 HSP 2250/50	■	
PureCare Bronze 60 HSP 6300/65		■
Kaiser Permanente* **		
HMO		
Platinum 90 HMO 0/10 + Child Dental Alt	■	
Platinum 90 HMO 0/15 + Child Dental	■	
Gold 80 HMO 250/25 + Child Dental	■	
Gold 80 HMO 500/30 + Child Dental Alt	■	
Silver 70 HMO 1650/55 + Child Dental Alt	■	
Silver 70 HMO 1800/55 + Child Dental Alt	■	
Silver 70 HMO 2250/50 + Child Dental	■	
Bronze 60 HMO 6300/65 + Child Dental	■	
PPO		
Platinum 90 PPO 0/15 + Child Dental	■	
Gold 80 PPO 250/25 + Child Dental	■	
Silver 70 PPO 2250/50 + Child Dental	■	
Bronze 60 PPO 6300/65 + Child Dental	■	
HSA-Compatible HMO		
Silver 70 HDHP HMO 2500/20% + Child Dental	■	
Bronze 60 HDHP HMO 6900/0 + Child Dental	■	
HRA-Compatible HMO		
Gold 80 HRA HMO 2250/35 + Child Dental	■	
MediExcel Health Plan		
Plan P5	■	
Plan P20	■	
Platinum Mirror Plan	■	
Gold Mirror Plan		■
National General		
PPO		
All creditable except those that don't offer an Rx Copay - Contact Rep	■	
Oscar		
EPO		
Platinum 90 EPO $0/$15 + Child Dental	■	
Platinum $0 Option 1	■	
Platinum $0 Option 2	■	
Gold 80 EPO $0/$30 + Child Dental Alt	■	
Gold $500 EPO	■	
Gold $1,000 EPO	■	
Gold $2,000 EPO	■	
Gold 80 EPO $250/$25 + Child Dental	■	
Silver $0 EPO	■	
Silver 70 EPO $1,500/$50 + Child Dental Alt	■	
Silver 70 EPO $2,250/$50 + Child Dental	■	
Silver $2,000 EPO	■	
Bronze 60 EPO $6,300/$65 + Child Dental	■	
Bronze $8,150 Option 1	■	
Bronze $8,150 Option 2	■	
Silver 70 HDHP EPO $2,500/20% + Child Dental	■	
Bronze 60 HDHP EPO $6,900/0% + Child Dental	■	
Sharp Health Plan		
HMO		
Platinum 90 HMO NG 1	■	
Platinum 90 HMO NG 2	■	
Platinum 90 HMO NG 3	■	
Platinum 90 HMO NG 4	■	
Platinum 90 HMO NG 7	■	
Platinum 90 HMO NG 8	■	
Gold 80 HMO NG 1	■	
Gold 80 HMO NG 2	■	
Gold 80 HMO NG 3	■	
Gold 80 HMO NG 4	■	
Gold 80 HMO NG 5	■	
Gold 80 HMO NG 6	■	
Gold 80 HMO NG 7	■	

	CREDITABLE	NON-CREDITABLE
Sharp Health Plan (Cont.)		
Silver 70 HMO NG 1	■	
Silver 70 HMO NG 2	■	
Bronze 60 HDHP NG 1*	■	
Mirrored Plans		
Sharp Premier Platinum 90 HMO 0/15 + Child Dental	■	
Sharp Performance Platinum 90 HMO 0/15 + Child Dental	■	
Sharp Premier Gold 80 HMO 250/25 + Child Dental	■	
Sharp Performance Gold 80 HMO 250/25 + Child Dental	■	
Sharp Premier Silver 70 HMO 2250/50 + Child Dental	■	
Sharp Performance Silver 70 HMO 2250/50 + Child Dental	■	
Sharp Premier Silver 70 HDHP HMO 2500/20% + Child Dental	■	
Sharp Performance Bronze 60 HMO 6300/65 + Child Dental	■	
Sharp Premier Bronze 60 HDHP HMO 6900/0 + Child Dental*	■	
Pseudo-Mirrored Plans		
Sharp Platinum 90 HMO 0/15/10% + Child Dental (PR/V/C)	■	
Sharp Platinum 90 HMO 0/15/250 + Child Dental (Pe/V/C)	■	
Sharp Gold 80 HMO 250/25/20% + Child Dental (Pr/V/C)	■	
Sharp Gold 80 HMO 250/25/600 + Child Dental (Pe/V/C)	■	
Sharp Silver 70 HMO 2250/50/20% + Child Dental (Pr/V/C-20%)	■	
Sharp Silver 70 HMO 2250/50/20% + Child Dental (Pe/V/C-300)	■	
Sharp Silver 70 HDHP HMO 2500/20%/20% + Child Dental (Pe/V/C)	■	
Sharp Bronze 60 HMO 6300/65/40% + Child Dental (Pr/V/C)†	■	
Sharp Bronze 60 HDHP HMO 6900/0/0 + Child Dental (Pe/V/C)	■	
PPO Companion Plans		
Please contact your Word & Brown representative		
HSA-Compatible HMO (Mirrored Plans)		
Silver 70 HDHP HMO 2500/20%/20% + Child Dental *	■	
Bronze 60 HDHP HMO 6000/40%/40% + Child Dental*†	■	
Bronze 60 HDHP NG 1*†		■
SIMNSA Health Plan**		
HMO		
5/15/250	■	
10/15/250	■	
Sutter Health Plus		
Platinum MS38 HMO	■	
Platinum MS41 HMO	■	
Platinum MS60 HMO	■	
Gold MS57 HMO	■	
Gold MS42 HMO	■	
Gold MS63 HMO	■	
Silver SD37 HDHP HMO	■	
Silver MS64 HMO	■	
Bronze SD28 HDHP HMO		■
Bronze MS66 HMO		■
UnitedHealthcare		
HMO - Choice Simplified		
Platinum $0 Ded.	■	
Gold $0 Ded.	■	
Gold $500 Ded.	■	
Gold $1,250 Ded.	■	
Gold (P.A) $1,500 Ded.	■	
Silver $2,250 Ded.	■	
Bronze w/Motion $6,900		■
Bronze (H.S.A) $6,900		■
Bronze HDHP $7,200	■	
State Mirrored Plans		
Platinum $0 Ded.	■	
Gold $250 Ded.	■	
Silver $2,250 Ded.	■	
Bronze (H.S.A) $6,900 Ded.		■
PPO/EPO Plans		
Platinum $0 Ded.	■	
Platinum $250 Ded.	■	
Platinum (P.A) $250 Ded.	■	
Gold $0 Ded.	■	

(Continued)

† *Plan becomes Medicare Part D Non-Creditable if Sharp is secondary payer to Medicare.*

* *Not creditable if Sharp is secondary payer to Medicare*

** *SIMNSA does not have an RX bin or PCN number as we do not dispense medications here in the United States. SIMNSA does not use a PMB, we have contracted pharmacies in Mexico where our members get their medications filled. SIMNSA does have a tax ID number for our Plan, 98- 0197925. Mailing address is below. SIMNSA HEALTH PLAN 2088 Otay Lakes Road#102 Chula Vista, CA 91915*

*** **Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.**

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Non-creditable Coverage Prescription drug benefit with current plan from employer is not as good as the pharmacy benefits offered through the new Medicare Part D standard plan

		CREDITABLE	NON-CREDITABLE
UnitedHealthcare (Cont.)			
Gold	$500 Ded.	■	
Gold	$1,000 Ded.	■	
Gold (P.A)	$1,500 Ded.	■	
Silver	$1,500 Ded.	■	
Silver	$2,250 Ded.	■	
Silver HDHP w/ Motion	$2,300 Ded.	■	
Bronze HDHP w/ Motion	$6,900 Ded.		■
Bronze HDHP	$7,200 Ded.	■	
State Mirrored PPO/EPO			
Platinum	$0 Ded.	■	
Gold	$250 Ded.	■	
Silver	$2,250 Ded.	■	
Bronze	$6,300 Ded.		■
Non-Differential PPO			
Silver	$2250 Ded.	■	
Western Health Advantage			
HMO			
Gateway 20 Platinum 90 HMO		■	
Gateway 30 Platinum 90 HMO		■	
Gateway 70 Platinum 90 HMO		■	
Sierra 25 Platinum 90		■	
Capital 15 Platinum 90 HMO		■	
Gateway 4010 Gold 80 HMO		■	
Gateway 4020 Gold 80 HMO		■	
Sierra 40 Gold 80		■	
Sierra 2000 Gold 80		■	
Sierra 4010 Gold 80		■	
Capital 250 Gold 80 HMO		■	
Gateway 5020 Silver 70 HMO		■	
Sierra 50 Silver 70		■	
Capital 2250 Silver 70 HMO		■	
Capital 6300 Bronze 60 HMO		■	
HDHP			
Gateway 2000 Gold 80 HDHP HMO		■	
Capital 2000 Silver 70 HDHP HMO			■
Sierra 6900 Bronze 60 HDHP HMO			■
Gateway 6900 Bronze 60 HDHP HMO		■	

Sierra Plans available only through Cal Choice

MEDICARE PRIMARY/SECONDARY COVERAGE

Employers with Medicare as a *primary payer* on claims for working employees age 65+

Employers that have employed less than 20 employees for each working day across each of 20+ calendar weeks in the current year or preceding year

Employers with Medicare as a *secondary payer* on claims for working employees age 65+

Employers that have employed 20 or more employees for each working day across each of 20+ calendar weeks in the current year or preceding year

Is Medicare the primary or secondary payer on claims?	
For age 65+ members of a small employer group plan that is Medicare Primary, how do you pay claim if they do not have Medicare Part B?	
Aetna	In small group, Medicare Part B is not mandatory. In accordance with CA law (28 CCR §1300.67.13), Aetna would pay primary in CA. However in states that allow it, members may see reduced payments on claims by what Medicare WOULD have paid had the member elected Part B. So it may be in the member's best interest to enroll in Part B.
Anthem Blue Cross	EOC Language as it relates to this dynamic: Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law. Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. **You should enroll in Medicare Part B as soon as possible.** This provision applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B or C of Medicare this Exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.
Blue Shield of California	If the member does not have Part B, we would pay Part B as primary.
CalCPA Health	If an individual is only enrolled in Medicare Part A CalCPA Health would pay primary on Part B services and secondary on Part A services.
Chinese Community Health Plan	Chinese Community Health Plan pays as primary.
EDIS	Medicare will be secondary; however, there could be circumstances where Medicare is primary. Contact your Word & Brown representative.
Health Net	Member has pt. A only. Medicare is primary for pt. A services which makes HN secondary. Since there is no Part "B" coverage HN is responsible for Part B services.

(Continued)

MEDICARE PRIMARY/SECONDARY COVERAGE

Is Medicare the primary or secondary payer on claims?	
For age 65+ members of a small employer group plan that is Medicare Primary, how do you pay claim if they do not have Medicare Part B?	
Kaiser Permanente	For KP members that don't elect Medicare Part B, Late enrollment penalty: -Premium goes up 10 percent for each 12-month period that member declines coverage. -Not a one-time penalty, but continues throughout enrollment. *Not imposed if you continue to work and get your health coverage from an employer or trust fund What happens if a member fails to enroll and assign Medicare A & B to Kaiser Permanente? If a member remains "unassigned," KP does not receive capitation. KP imposes a higher rate to compensate for the fact that the member does not have one or more Medicare parts.
MediExcel Health Plan	MediExcel does not coordinate benefits with Medicare unless it is an emergency situation in which MediExcel would pay secondary.
National General	We do not assume Medicare Part B payment, we pay as primary on Part B charges as long as the Coordination of Benefits (COB) indicates Part A coverage only.
Oscar	If the member does not have part B, we would pay part B as primary.
Seniors Choice	If a member does not have Medicare Part B, they are not eligible for Seniors Choice. Persons enrolling into Seniors Choice must have Medicare A & B and be 65+.
Sharp Health Plan	Sharp will pay claims as primary.
Sutter Health Plus	SHP follows standard COB rules which may vary based on employer group size. Generally, SHP would pay as primary for services that are not covered by Medicare or for which Medicare is the secondary payer. Less than 20 employees – Medicare is primary 20 or More employees – Medicare is secondary
UnitedHealthcare	Having Part B is <u>not</u> a requirement for enrollment of the "eligible" employee. When Medicare Primary (1-19 EEs) is marked on Group Application: HMO plans - UnitedHealthcare pays primary PPO plans - Rates are the same whether or not member has Medicare. UnitedHealthcare Claims Department CAN adjust the claim to account for the amount Medicare Part B would have covered; so there is potential for a member's out of pocket cost to be higher
Western Health Advantage	Medicare would be primary for services covered by Part A and WHA would be secondary. For services covered by Part B, WHA would be prime and there is no secondary coverage

Click on symbol to be redirected to online resource

ONLINE SERVICES

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
	aetna.com	anthem.com	blueshieldca.com	calcpahealth.com	calchoice.com	cchphealthplan.com	employerdriven.com	healthnet.com	kp.org
EMPLOYER SERVICES									
View Employee Add-Ons/ Terminations	●	●	●	●[5]	●		●	●	●[2]
Rates For EEs/ Dependents	●	●		●[5]	●		●	●	●
Premium Payment	●[4]	●	●	●	●	●	●	●	●[2]
Online Billing Payment	●	●	●	●	●		●	●	●[2]
Online Addition/ Termination of Employee	●	●	●	●[9]	●		●	●	●[2]
View Directory	●		●	●	●	●	●	●	●[2]
Download Forms	●	●	●	●	●	●	●	●	●[2]
E-Mail Customer Service	●	●	●	●	●	●	●	●	●[2]
EMPLOYEE SERVICES									
View Claims Status	●[1]	●	●	●[10]			●	●	
Order Permanent ID Cards	●[1]		●	●[10]	●		●	●	●
Print Temp. ID Cards	●[1]		●	●[10]				●	
View Benefits	●[1]	●	●	●[10]	●	●	●	●	●
View Current PCP Or Doctor	●[1]	●	●	●[10]		●		●	●
Change Doctor	●[1]		●	●[10]				●	●
View Directory	●[1]	●	●	●[10]	●	●	●	●	●
Download Forms	●[1]	●	●	●[11]	●	●	●	●	●
Book Doctor Appointments				●[12]					●
BROKER SERVICES									
Manage Group Acct	●	●	●	●[5]	●		●	●	
Commission Information	●	●	●		●		●	●	
Group Info (e.g. Add-Ons)	●	●	●	●[5]	●		●	●	
Online Only Agent Appt, Paper App. or Both?	*Online Only*	*Online Only*	*Paper Application Only*	*Both*	*Paper Application Only*	*Paper Application Only*	*Both*	*Both*	*PDF Application submitted in conjunction with Group Application*

1 *All features are available to members who enroll on Aetna Navigator. There is no cost for Aetna Navigator.*
2 *Employer must sign up with Kaiser Permanente's Customer Account Services in order to access online services.*
3 *Employer eServices sign-on will be moving to Optum ID. You may register for an Optum ID once you get an email invitation with instructions to create a new Optum ID or to connect your existing Optum ID with your Employer eServices account(s). If you have more than one Employer eServices ID you will receive an email for each ID with specific action steps. Employees must register at myuhc.com®.*
4 *Employer should be directed to www.aetna.com/employer-plans/index.html.*
5 *Available upon employer's request.*
6 *Employee must be on a high deductible plan to view claims.*
7 *Only with Group approval.*
8 *Brokers must register at unitedeservices.com. If Broker needs access to Manage Group Account or Group Info (e.g. Add-Ons), then he/she needs to be tied to the group through employereservices.com.*
9 *View-only access of the enrollment portal is available to all employers upon request. Employer groups of 20 or more full-time employees may request access to edit enrollment in the portal. Employers that request this option must attend a 1 hour instructional webinar. Employer groups that have edit-access must process all enrollment changes in the portal.*
10 *This feature is can be accessed by logging into the carrier websites: www.anthem.com/ca (medical); www.expressscripts.com (Rx); www.deltadentalins.com (dental); www.vsp.com (vision)*
11 *Forms can be found on the CalCPA Health website: www.calcpahealth.com*
12 *Members can book online doctor appointments through LiveHealth Online. More information regarding the LiveHealth Online program can be found here: http://www.calcpahealth.com/livehealthonline/*

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Click on symbol to be redirected to online resource

ONLINE SERVICES

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare HMO	UnitedHealthcare PPO	Western Health Advantage
	mediexcel.com	ngah-ngic.com	hioscar.com	sharphealthplan.com	simnsa.com	sutterhealthplus.org	Employer: employereservices.com Employee: myuhc.com		westernhealth.com
EMPLOYER SERVICES									
View Employee Add-Ons/ Terminations		●	●	●		●		●[3]	●
Rates For EEs/ Dependents		●	●	●		●			
Premium Payment			●	●				●[3]	●
Online Billing Payment		●	●	●		●		●[3]	●
Online Addition/ Termination of Employee	●		●	●				●[3]	●
View Directory	●	●	●	●	●	●			●
Download Forms	●	●	●	●	●	●	●	●[3]	●
E-Mail Customer Service		●	●	●		●	●[13]	●[13]	●
EMPLOYEE SERVICES									
View Claims Status		●	●			●	●	●[3]	●[6]
Order Permanent ID Cards		●		●		●	●	●[3]	●
Print Temp. ID Cards		●	●	●		●	●	●	●
View Benefits		●	●	●		●	●	●[3]	●
View Current PCP Or Doctor		*Depends on network*	●	●	●	●	●	●[3]	●
Change Doctor			●	●		●	●	●	●
View Directory		●	●	●	●	●	●	●[3]	●
Download Forms	●	●	●	●	●	●	●	●	●
Book Doctor Appointments	●		●		●	●			
BROKER SERVICES									
Manage Group Acct	●	●	●			●	●[8]	●	●
Commission Information			●			●	●[8]	●	●
Group Info (e.g. Add-Ons)	●	●	●[7]		●	●	●[8]	●	
Online Only Agent Appt, Paper App. or Both?	*Both*	*Online only*	*Online Only*	*N/A*	*Both*	*Paper Application Only*	*Paper Application Only*	*Paper Application Only*	*Paper application only*

1 All features are available to members who enroll on Aetna Navigator. There is no cost for Aetna Navigator.
2 Employer must sign up with Kaiser Permanente's Customer Account Services in order to access online services.
3 Employer eServices sign-on will be moving to Optum ID. You may register for an Optum ID once you get an email invitation with instructions to create a new Optum ID or to connect your existing Optum ID with your Employer eServices account(s). If you have more than one Employer eServices ID you will receive an email for each ID with specific action steps. Employees must register at myuhc.com®.
4 Employer should be directed to www.aetna.com/employer-plans/index.html.
5 Available upon employer's request.
6 Employee must be on a high deductible plan to view claims.
7 Only with Group approval.
8 Brokers must register at unitedeservices.com. If Broker needs access to Manage Group Account or Group Info (e.g. Add-Ons), then he/she needs to be tied to the group through employereservices.com.
9 View-only access of the enrollment portal is available to all employers upon request. Employer groups of 20 or more full-time employees may request access to edit enrollment in the portal. Employers that request this option must attend a 1 hour instructional webinar. Employer groups that have edit-access must process all enrollment changes in the portal.
10 This feature is can be accessed by logging into the carrier websites: www.anthem.com/ca (medical); www.expressscripts.com (Rx); www.deltadentalins.com (dental); www.vsp.com (vision)
11 Forms can be found on the CalCPA Health website: www.calcpahealth.com
12 Members can book online doctor appointments through LiveHealth Online. More information regarding the LiveHealth Online program can be found here: http://www.calcpahealth.com/livehealthonline/
13 Email: clientserviceoperations@uhc.com

RENEWAL INFORMATION - MEDICAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Are 2-life husband/wife groups eligible or will they be required to move to IFP?	*These groups are not eligible for Small Group.* *There must be one enrolled W-2 employee who is not the owner and not the owner's spouse.*	*A qualified small group must consist of an owner and a common law employee. Husband/wife/ domestic partner groups do not constitute a small group.*	*Sole Proprietor Husband and Wife groups will not be eligible as a small group business. Groups that are LLC's, Inc., etc. can have spouse, but the spouse must be a W2 employee, if they are both owners they would not qualify.*	*CalCPA will write husband/ wife groups with the appropriate paperwork.*	*No—All 2 life groups must include at least one medical enrolled employee who is not a business owner or spouse.*	*No - these groups are not eligible. There must be one enrolled W-2 employee who is not the owner nor owner's spouse.*	*Yes*	*There must be a minimum of one W-2 employee who is not a spouse of the owner or partner.*	*An Employer must have at least 1, but not more than 100, permanent, active, full-time employees, which excludes spouses and owners, for at least 50 percent of the preceding calendar quarter or preceding calendar year.*
Which groups do you recertify at renewal?	*All groups are requested to complete Employer Verification Form prior to renewal*	*Groups are randomly selected.*	*Groups can be recertified randomly or if something triggers, (i.e. several terms, several out of state ee's enrolled etc.) but this is an underwriting discretion*	*DE9/DE9C is required for all groups at renewal. All groups may be subject to recertification.*	*1-4 life groups*	*All groups are requested to complete annual information update form at renewal.*	*All groups are requested to complete Employer Verification Form at renewal*	*Call your Word & Brown representative.*	*Any group may be required to recertify at any time. However, new groups enrolled in the last 12 months will go through certain scheduled recertifications:* *-Groups with 5 or fewer members must recertify on the third renewal after two full renewals.* *-Groups with 6 to 15 members must recertify on the fifth renewal after four full renewals* *-Groups with 16 or more members must recertify on the seventh renewal after six full renewals.* *-New business groups must recertify on their one-year anniversaries*
Where does a broker go with questions about the group's renewal? Account Manager or 800 Number?	*Account Client Managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Broker Services 1-800-678-4466* *Account Manager as assigned to ACE agents*	*Producer Services 800-559-5905* *Account Manager is only for Renewals and Escalated issues and upsells of Dental, Vision and Life*	*Banyan Administrators 877-480-7923*	*Renewals at 800-542-4218*	*Sales Department* *For existing groups:* *Account Management 888-681-3888*	*Renewal Department email: renewal@employerdriven.com Phone: 888-886-7973*	*-Renewals & WP changes, benefit changes, adds/deletes at renewal, etc. can be Acct Mgmt. - (800) 447-8812, opt.2* *-Benefit, claims & eligibility inquiries from a GA, Brokers & Benefits Administrators can contact ASU (Account Services Unit) - (800) 547-2967 or email: HN_Account_Services@healthnet.com* *-Benefit, claims & eligibility inquiries from a member can contact Member Services - (800) 361-3366* *-Outside of the renewal period, enrollment forms can be sent to EnrollmentUnit_North@healthnet.com or faxed to (916) 935-4420* *-For billing issues/ questions contact accounting at (800) 224-8808 Opt. 3*	*Employer/ Broker Account Administration - Customer Connection Team* *800-790-4661 option 3*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Brokers have access to Aetna's online enrollment system—e-enroll. They can run a report to view membership after changes are processed.*	*Yes - through Producer Toolbox at: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc*	*Yes - Group level changes are done in the renewal center (SGOR tool). Employee level changes are done on employer connection plus. www.blueshieldca.com*	*Contact Banyan Administrators to gain system access.*	*Yes www.calchoice.com*	*No*	*Yes yourbenportal.com*	*Yes: https://www.healthnet.com/portal/broker/home.ndo* *Note: in order for a broker to have access to do adds/terms, that the ER needs to register on healthnet.com & give their broker access.*	*brokernet.kp.org*

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RENEWAL INFORMATION - MEDICAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Are 2-life husband/wife groups eligible or will they be required to move to IFP?	*There must be a minimum of one W-2 employee who is not a spouse of the owner or partner.* *MediExcel does not offer IFP Products.*	*They will be eligible*	*Required to move to IFP*	*No - an Employer must have at least 1, permanent, active, full-time employee, which excludes spouses and owners.*	*No*	*No, an employer with only an owner and partner or with only an owner and spouse is not eligible. A minimum of one eligible common law employee is required to be considered eligible.*	*Sole proprietors, husband/wife and owner-only groups are not eligible.*	*There must be a minimum of one W-2 employee who is not an owner or partner or spouse of an owner or partner.*
Which groups do you recertify at renewal?	*MediExcel may elect to verify the eligibility of any group that it suspects no longer meets eligibility criteria*	*All groups are underwritten at time of renewal*	*In addition to random recertification, Oscar may elect to verify the eligibility of any group that it suspects no longer meets eligibility criteria*	*Sharp reserves the right to random recertification. Sharp will provide notice if recertification is needed.*	*SIMNSA reserves the right to re-certify all groups*	*All groups with current enrollment of 1-125.*	*All groups are subject to recertification*	*All groups are requested to complete Group Renewal Confirmation at renewal.*
Where does a broker go with questions about the group's renewal? Account Manager or 800 Number?	*sales@ mediexcel.com*	*The broker would work with the account manager.*	*Account manager/ sales executive*	*Please contact the Account Manager*	*Chuidobro@ simnsa.com 1-800-424-4652*	*Contact the account manager.*	*Renewal Account Consultant*	*Your designated Account Manager or Sales Executive*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*No*	*No*	*business. hioscar.com*	*No*	*No*	*Yes, visit Shplus. org/brokerportal*	*HMO Medical: No* *PPO Medical/ All Specialty: employereservices. com*	*Yes. westernhealth. com*

RENEWAL INFORMATION - MEDICAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Do new enrollees have the ability to register online and print temporary ID cards?	*Once a new enrollee is in the Aetna system, they can register for Aetna Navigator. One of the functions of Aetna navigator is to print ID cards.*	*Once enrolled, they can register to view their benefits, etc at anthem.com/ca. Members can request replacement ID cards at anthem.com/ca. Additional cards can be ordered through the Membership department at 1-855-383-7248.* *Members ID card can also be accessed on Anthem Anywhere app.*	*Yes, at: blueshieldca.com under the member portal*	*Yes, this feature can be accessed by logging into the carrier websites: www.anthem.com/ca (medical)* *www.express-scripts.com (Rx)* *www.deltadentalins.com (dental)* *www.vsp.com (vision)*	*Once a new enrollee is approved and active, they can register online and order an ID card. However, you CANNOT print a temporary ID card - only request a permanent ID card online.*	*Once a new enrollee is approved and active, they can register online and order an ID card via the CCHP Mobile App, available on the Google Play Store and Apple App Store.*	*No*	*Yes—once the applicant is approved and active, they can register online and download a copy of their ID card.*	*No*
How far in advance do groups receive their renewal material?	*Per CA law, Groups must be mailed their renewals 60 days in advance of the renewal date.*	*Approximately 65 days*	*Approximately 60 days*	*60 days*	*60 days*	*60 days*	*Approximately 60 days*	*60 days prior to renewal*	*Approximately 90 days before a group's annual renewal date, Kaiser Permanente will notify the group of any rate or plan changes and send the group a renewal kit.*
How far in advance do brokers receive their renewal material?	*Per CA law, brokers receive their renewals 60 days in advance of the renewal date. Brokers can view the renewals Producer World as soon as they are mailed (usually 5 – 7 days in advance of mail).*	*Brokers can also view the renewals on Producer toolbox between 60-70 days.*	*Approximately 90 days*	*60 days*	*60 days*	*60 days*	*Approximately 60 days*	*Approx. 67 days prior to renewal*	*A renewal notice is provided to brokers approximately 75 days before the contract renewal effective date.*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Brokers can go to Producer World and access renewal online OR contact Account Client Managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Brokers can access Producer Toolbox at: https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc*	*Broker can pull a PDF copy of their renewal by logging into producer connection under online renewals.*	*Call Banyan Administrators*	*Renewals at 800-542-4218*	*Please contact Sales Dept. of CCHP 877-224-7808*	*Contact E.D.I.S. renewal department Email: renewal@employerdriven.com Phone: 888-886-7973*	*If broker needs to contact Account Manager, these are assigned by broker location or group's region, please provide contact information list by broker location or group region. Anyone from Account Management team can also assist. Broker can contact Account Management at 1-800-447-8812 option 2 for assistance. They can also email their dedicated Account Manager for assistance.*	*Employer/Broker Account Administration - Customer Connection Team 800-790-4661 option 3*

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RENEWAL INFORMATION - MEDICAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Do new enrollees have the ability to register online and print temporary ID cards?	*No*	*Yes, once the groups new plan year is established in the system.*	*Yes*	*Yes—members can register online and view plan information and print temp ID cards.*	*No*	*Yes, new enrollees can register and print ID cards through the SHP Member Portal.*	*Yes www.myuhc.com*	*Yes - members can register online and view plan information or print ID cards.*
How far in advance do groups receive their renewal material?	*90 days*	*As soon as broker delivers it. If the broker doesn't deliver within 10 days of their receipt, the employer is notified electronically of their ability to view the offer online.*	*60 days*	*Approximately 60-90 days before a group's annual renewal date.*	*We provide the renewal 60 days in advance or upon brokers request.*	*Renewals are sent 60 days before the group's renewal date.*	*Renewal should be received by the group about 75 days before the renewal date. 60 days at the latest*	*120 days in advance.*
How far in advance do brokers receive their renewal material?	*90 days*	*60 days*	*60 days*	*Approximately 60-90 days before a group's annual renewal date. Renewal is issued at the same time as to Employer.*	*Upon request*	*Renewals are sent 90 days before the group's renewal date.*	*Same as above Brokers also have access to renewals on unitedeservices.com*	*120 days, just prior to group renewal being sent* *Renewals are posted in their broker portals and an email notification is sent to advise them once available*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*sales@mediexcel.com*	*They can view/ retrieve renewal offers online. In addition, they can contact their account manager.*	*Broker support*	*Contact Account Manager*	*Chuidobro@simnsa.com*	*Copies of renewals are available to the broker through the Broker Portal.*	*Broker should contact Renewal Account Consultant. Please see contact sheet previously provided*	*Broker should contact their designated Sales team representative or WHA Sales directly at 916-563-3198 or 888-499-3198.*

RENEWAL INFORMATION - MEDICAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Where does a broker get SBCs for renewal groups?	SBCs can be accessed at: https://www.aetna.com/sbcsearch/home	SBCs can be accessed at https://sbc.anthem.com	SBC's are automatically sent to the employer, but if a broker wants to pull they can pull on Producer Connection https://www.blueshieldca.com/bsca/find-a-plan/summary-of-benefits-and-coverage/home.sp?WT.mc_id=otc-prd-sbc-1367	www.calcpahealth.com or by calling Banyan Administrators	www.calchoice.com/documents/	SBCs can be accessed at https://cchphealthplan.com/employer-member	SBC's are automatically sent to the employer, but a broker can access them via www.yourbenportal.com	www.healthnet.com/sbc	In accordance with the ACA, Kaiser Permanente provides downloadable versions of the Summary of Benefits and Coverage (SBC) documents for each of their plans on kp.org/smallbusiness-sbc/ca
Deadline for submission of group level renewal changes & their effective date?	Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.	The completed documentation, including all necessary Anthem Blue Cross forms, must be received by Anthem Blue Cross within 30 days of the requested anniversary date. Non-anniversary benefit modifications will not be allowed.	We prefer to receive changes by the 1st of the renewal month but will accept changes through the renewal month up to the last business day of the renewal month.	The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.	We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.	14 days before renewal	Prefer changes are submitted prior to the end of the month preceding the renewal, but will accept changes through the renewal month up to the last business day of the renewal month, or until the signed agreements are submitted.	The last day of the group's renewal month. We must receive this in house either through fax or email to process the change.	An employer must submit change requests to Kaiser Permanente Small Business on or before the last business day of the renewal effective month. Change requests must contain an email date, postmark, or fax date stamp to prove the change was submitted on time. -A plan change request received by the 15th of the effective month will be applied retroactively to the 1st of the month. -A plan change request received after the 15th of the effective month will be applied to the 1st of the following month. -Deductible accumulation amounts may not be transferable.
Deadline for submission of employee/ dependent renewal changes & their effective date?	Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.	A. Covered subscribers may move to a different product offered by their group at the anniversary month. B. A subscriber can request a change in medical benefits by completing the Employee Change Form or the Plan Change Request form on their group's anniversary date.	Same as above	The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.	We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.	14 days before renewal	Prefer changes are submitted prior to the end of the month preceding the renewal, but will accept changes through the renewal month up to the last business day of the renewal month, or until the signed agreements are submitted.	The last day of the group's renewal month. We must receive this in house either through fax or email to process the change.	Change requests must contain an email date, postmark, or fax date stamp to prove the change was submitted on time. -A plan change request received by the 15th of the effective month with be applied retroactively to the 1st of the month. -A plan change request received after the 15th of the effective month will be applied to the 1st of the following month. -Deductible accumulation amounts may not be transferable.
Email address and/or fax number for submission of renewal change forms?	Contact Dedicated Account Client Managers designated by market with direct phone/email access. Aetna Answer Team: Phone: 1-800-343-6101 (available 5:00 am - 5:00 pm PST) E-mail: WestAAT@aetna.com Account Client Manager Team: nationalSSCSmallGroup@aetna.com	Small.Group@Anthem.com or Fax 855-750-2227	Small.group@blueshieldca.com	calcpahealth@calcpahealth.com	Email: memberprocessing@calchoice.com Fax: (714) 558-8000	sales@cchphealthplan.com	Underwriting@employerdriven.com Fax: 559-635-6527	Renewal changes forms can be emailed to your dedicated Account Manager or faxed to 800-303-3110. For your Account Manager's information, please call Account Management at 800-447-8812 option 2.	Northern CA groups 858-614-3344 - fax Southern CA groups 858-614-3345 - fax csc-sd-sba@kp.org

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RENEWAL INFORMATION - MEDICAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Where does the broker get SBCs for renewal groups?	*Website (mediexcel.com) or sales@mediexcel.com*	*They are provided with the reissue offer to the group*	*Business.hioscar.com*	*The renewal includes a copy of the SBC. Please contact Account Manager to request another copy.*	*Chuidobro@simnsa.com*	*Copies of presale SBCs are available on the Broker Portal under "Forms and Resources." Final SBCs are available on the Broker Portal on the renewal effective date.*	*Renewal Account Consultant or CAShip@uhc.com. Generics (without coverage dates) are also available on uhctogether.com/casb*	*SBCs are available electronically through the online broker portal for in-force clients or broker may contact WHA Sales to request copies for a specific plan or group.*
Deadline for submission of group level renewal changes & their effective date?	*Group level changes must be submitted by the 10th day of the effective month*	*The day before the group's plan year begins*	*Day before renewal date*	*An employer must submit change requests to Sharp Health Plan Account Manager on or before the renewal effective month.*	*A week before the group's renewal month*	*SHP will allow group level renewal changes up to the last day of the renewal month; however, plan changes may not be reflected for two or three invoice cycles.*	*Group level changes must be submitted by the 5th day of the effective month.*	*Group level changes must be submitted prior to the renewal date.*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*10 days after effective date*	*The day before the group's plan year begins*	*Day before renewal date*	*An employer must submit employee change requests to Sharp Health Plan Account Manager during open enrollment month.*	*Group level changes must be submitted prior to the renewal date*	*SHP will accept employee / dependent renewal changes up to the last day of the renewal month. The change would be effective the 1st of the renewal month.*	*30th day of the renewal month.*	*Within 30 days of their effective date*
Email address and/or fax number for submission of renewal change forms?	*applications@mediexcel.com*	*NGBSSelfFunded@ngic.com*	*N/A - Forms must be submitted electronically by broker or GA.*	*Email changes to Account Managers or fax to 858-499-8246.*	*Email: chuidobro@simnsa.com* *Fax: 619-407-4087*	*shpaccountservices@sutterhealth.org*	*Send directly to Renewal Account Consultant*	*Send to either to designated Sales team representative or to: whasales@westernhealth.com* *Fax 916-568-1338*

RENEWAL INFORMATION - MEDICAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Which submission method offers the fastest processing time for renewal changes?	*Contact Dedicated Account Client Managers by phone or E-mail.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*E-mail or fax*	*You can view/retrieve and make renewal changes online or email them to small.group@blueshieldca.com.* *Either submission is 7-10 business days standard processing.*	*Email*	*Email or fax*	*Email*	*Email*	*Electronically via email with all completed attachments.*	*They are both equal for processing time*
What changes are allowed at renewal?	*During OE, most changes are allowed, including plan selection, employee coverage, dependent coverage, group waiting period, etc.*	*During OE, most changes are allowed, including plan selection, employee coverage, dependent coverage, group waiting period, etc.*	*During Open enrollment Group and Member level changes.*	*During OE, most changes are allowed, including plan selection, employee coverage, dependent coverage, group waiting period, group minimum hourly requirement, etc.*	*During OE, most changes are allowed, including plan selection, employee coverage, dependent coverage, group level changes, etc.*	*During OE, most changes are allowed, including plan selection, employee coverage, dependent coverage, group waiting period, etc.*	*Group & member level changes*	*Upon renewal, group's can change their plan options, contribution, WP, etc.*	*During open enrollment:* *-Groups may offer health coverage to employees who did not elect coverage when they became eligible.* *-Subscribers may also add dependents not previously enrolled.* *-If group offers multiple plan options, current subscribers may change from one plan to another.*
Forms required?	*Plan Sponsor Signature Page included in the renewal package* *Enrollments form for newly added membership.* *List of changes for existing memberships changes*	*If group renews as is, no form is needed.* *If group is going to make plan changes, a Plan Change form or Member applications will be required to add or remove dependents.*	*All changes should be done on employer connection plus and the online renewal tool, forms are required if not done online.*	*The firm will receive their renewal 60 days of their renewal date.* *The forms that are included are:* • *Cover Page* • *Medical/ Rx Plan Change Form(s)* • *Dental/ Vision Plan Change Form*	*Contact your Renewal Specialist at 1-800-542-4218*	*Email request for changes. Forms not required.*	*There may be forms required if making certain changes.*	*No forms are required at renewal.*	*Varies depending on each group's needs.* 1. *Contract Change Request* 2. *Customer Address or Name Change Request* 3. *Employee/ Dependent Change* 4. *Employee Enrollment* 5. *Plan Add/ Change Request* 6. *Subscriber Termination and Transfer*
Can group add dental, vision or life at renewal, or can it be added anytime?	*Can be added at any time. Renewal will coincide with medical renewal date.*	*Ancillary products can be added at any time - the effective date would be 1st of month following receipt of all complete documentation. The renewal date if merging with Medical will be the Medical renewal date.*	*Dental, Life, or Vision can be added at the group level off of OE if they do not already have it.*	*Dental can only be added during OE, or when adding Vision.* *Vision, life, and LTD can be added any time.*	*Buy-up dental, vision, and life can be added at any time once a year and at renewal.* *Voluntary dental can be added at any time once a year (but not to replace buy-up dental) and at renewal.*	*At renewal only*	*Dental, vision and/ or term life can be added at the group level off of open enrollment if they do not already have these lines of coverage*	*Dental, Vision, and Life can be added at anytime. Subject to Underwriting review.* *Please contact Account Management at 800-447-8812 option 2*	*You can add a new dental plan or change your current plan only at renewal, excluding pediatric dental.*

† *This question references groups that had a longer waiting period than what is allowable by health reform law, so they must be transitioned into a compliant waiting period (In California, 60-day maximum).*

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RENEWAL INFORMATION - MEDICAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Which submission method offers the fastest processing time for renewal changes?	*Email applications@mediexcel.com*	*Emailing*	*Online at business.hioscar.com*	*Submission to Account Manager*	*By email enrollment@simnsa.com*	*By email shpaccountservices@sutterhealth.org*	*Renewal Account Consultant*	*There is no delay by submission method. All changes will be processed in the order received.*
What changes are allowed at renewal?	*Plan selection, adds/terms, contribution amounts*	*Plan benefits, network, specific deductible and enrollment changes.*	*Plan selection, waiting period, adds/terms, contribution amounts*	*Plan changes, enrollment changes, group variable changes (eligible hours, etc.) are allowed at open enrollment/ renewal*	*Plan changes, enrollment changes, contribution changes or waiting period changes*	*Plan changes and enrollment changes.*	*Plan changes, waiting period changes, contribution, Employee enrollment changes*	*Plan changes, enrollment changes, contribution changes or waiting period changes.*
Forms required?	*Enrollment/ Change/ Termination Form*	*At renewal, we require the following:* 1. *A signed renewal proposal* 2. *Signed Business Associate Agreement* 3. *Signed Administrative Services agreement.*	*Forms are not required for renewal.*	*Renewal confirmation form or written communication (email confirmation will suffice).*	*Forms are not required for renewals.*	*For plan changes the employer group must submit the Current Year Small Group Renewal Confirmation form.* *For employee/ dependent changes, the employer group must submit the Small Group Plan Employee Enrollment/ Change Form.*	*Renewal spreadsheet*	*Yes, Group Renewal Confirmation and GSA Cover Sheet*
Can group add dental, vision or life at renewal, or can it be added anytime?	*These changes can only be made at renewal.*	*We currently don't offer these options*	*N/A - Oscar does not offer dental, vision or life*	*These changes can only be made at renewal.*	*Dental may be added at anytime*	*Groups can only add dental or vision at renewal.*	*Dental and vision can be added at any time but may require additional approval off-renewal. Must be a new line of coverage, not a change to an existing line.*	*Dental or vision riders can be added at renewal*

UNDERWRITING REQUIREMENTS

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Are Union/ Non-union exclusions allowed?	*Union carve outs that meet the definition of a Small Employer with a minimum of 5 enrolled employees who reside within the Aetna California network service area. Other types of carve outs are not eligible.*	*Union/non-union exclusions are not allowed.* *The group must be actively engaged in a business or service. On at least 50% of its working days during the previous calendar quarter or calendar year, the group employed at least one, but not more than 50, eligible employees, the majority of whom were employed within this state. The group was not formed primarily for purposes of buying a health care plan. A bona fide employer-employee relationship exists. A copy of the Union Roster will be required from the employer identifying Union members.*	*Yes—if total group size is 100 or less.* ***UNION EMPLOYEES**:* *When a small group employer, in compliance with a collective bargaining agreement, is purchasing healthcare benefits for his union employees, those union employees will be considered eligible by Blue Shield.* ***UNION TRUST PLANS:*** *When a small group employer is contributing to a labor fund, in compliance with a collective bargaining agreement, for the purchase of healthcare benefits, that employer's union employees will be considered ineligible by Blue Shield. Copies of the union's statement of ERISA rights will be required.* ***FOR BOTH:*** *If total employees (union plus non-union) is 100 or less, group will be guarantee issue.* *Legal documentation verifying employer's method of compliance with the collective bargaining agreement is required.*	*Not allowed*	*Yes - coverage available for non-union only. Group must submit union billing to underwriting for verification that all other employees have union coverage*	*Yes*	*Yes*	*Carve-outs are not available*	*- The total number of both union and non-union eligible employees must be 1 to 100 employees in order to be eligible for small group coverage.* *- Employers who own the union contract and do not pay into the union trust fund are eligible to enroll the entire group of union and non-union employees.* *- When union employees receive health coverage through the union trust fund established by a collective bargaining agreement, then only non-union employees are eligible for Kaiser Permanente small group coverage. The employer is required to submit:* *- A copy of the collective bargaining agreement showing contributions to the trust fund, and* *- A statement of ERISA rights from the union trust summary plan description*
Will new business carve out groups be eligible?†	*Union carve outs that meet the definition of a Small Employer with a minimum of 5 enrolled employees who reside within the Aetna California network service area. Other types of carve outs are not eligible.*	*No, not allowed*	*No*	*No carve outs allowed*	*No*	*No*	*Yes*	*No*	*As part of the new health care reform law, non-grandfathered, fully insured group health plans are subject to non-discrimination rules. A plan may be considered discriminatory if it has:* *• Different waiting periods for different classes of employees* *• Different contribution amounts for different classes of employees* *• Different carve-outs and benefit options for management that are not available for other employees* *• If your plans include management carve-outs or distinct benefit features for different classes of employees -- and you wish to keep them--you should consult with your broker or legal counsel to determine whether these plans qualify as non-discriminatory. Then, if you wish to keep these plans, you should retain grandfathered status for the plans.* *• Grandfathered status will ensure your group is not subject to substantial fines for non-compliance.* *• To help groups with non-grandfathered plans avoid these issues, Kaiser Permanente is no longer promoting management carve-outs to non-grandfathered coverage.* *Because groups, not insurers, are responsible for applying the non-discrimination requirements to your plan options, you may need to seek professional advice to determine whether the non-discrimination rules of health care reform apply to your particular situation.*
Will they need to prove compliance with IRS code 105(h) or sign a document indicating they do comply	*No*	*N/A*		*N/A*		*N/A*		*No*	
Will existing carve out groups be eligible to continue coverage?†	*Union carve outs that meet the definition of a Small Employer with a minimum of 5 enrolled employees who reside within the Aetna California network service area. Other types of carve outs are not eligible.*	*Groups will be re-certified at renewal and will be required to become compliant.*	*Yes*	*No carve outs allowed*	*No carve outs allowed*	*Yes*	*Yes*	*Yes*	*Grandfathered plans are not subject to the non-discrimination rules. Existing groups may renew grandfathered plans that were sold as management carve out.*
Will they need to prove compliance with IRS code 105(h) or sign a document indicating they do comply?	*No*		*No, they will not need to prove compliance nor sign a document indicating compliance*	*N/A*		*No*		*No*	*No*

† *The Affordable Care Act (ACA) requires group health plans to comply with IRS code 105(h) which prohibits discrimination in favor of highly compensated employees. After reviewing the comments submitted in response to proposed regulations, the IRS postponed implementation of this portion of ACA until they release further guidance. In anticipation of that guidance, some health plans already have decided to no longer accept carve-outs. Once this guidance is published the responses outlined above may change. Word & Brown will keep focused on this important issue and update you promptly regarding any changes.*

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UNDERWRITING REQUIREMENTS

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Are Union/ Non-union exclusions allowed?	*Yes*	*Yes*	*For small employer groups with union and non-union employees, where the union members receive health benefits through a collective bargaining agreement, Oscar will consider the non-union employees eligible for coverage, provided:* • *The employer provides a copy of the collective bargaining agreement to prove the employer provides coverage and contributes to the trust plan.* • *The statement of ERISA Rights is provided from the union trust fund (summary plan description)* • *Union members who are not eligible to enroll in the Small Business policy, are not counted for purposes of determining group size or participation requirements. Participation requirements are based on the employees who are permitted to enroll with Oscar.*	*Yes - if approved by Sharp underwriting. A minimum of 5 must enroll. 100% participation is mandatory. Call representative*	*Yes*	*An employer with a population covered by a union contract may offer an SHP medical plan to nonunion employees. The employer must follow the PPACA guidelines; if the union and nonunion employees total more than 100 full-time or full-time equivalent eligible employees, the group must be written as a large group employer, even if SHP is not covering the entire population. SHP may offer coverage to an out-of-state employer with California-eligible employees who live, work or reside in the SHP licensed service area.*	*<u>Union/ Non-Union Group</u>* *--In determining group size both Union and Non-Union are taken into consideration.* *--Groups consisting of Union/Non-Union employees must also provide a copy of their union bill.*	*Yes - subject to Underwriting approval*
Will new business carve out groups be eligible?†	*Yes*	*Yes*	*No*	*Yes*	*N/A*	*SHP will allow carve-out of eligible employee populations when the other eligible employee population is covered under another health plan contract such as:* *• Union/Non Union* *• Management* *• Employee only within SHP's approved service area* *• Same participation rules apply* *• When determining business line coverage, the total population must be considered. If the total eligible employee count is more than 101+, the carve-out population must be written in large group*	*No. Only Union/ Non-Union permitted*	*Yes - Employer is responsible to ensure they are in compliance*
Will they need to prove compliance with IRS code 105(h) or sign a document indicating they do comply	*Yes*	*Yes*		*No*	*N/A*	*No, but Underwriting has the right to request any documents to validate compliance.*	*N/A*	*No*
Will existing carve out groups be eligible to continue coverage?†	*N/A*	*Yes* *Existing groups do not require revalidation. They sign a carve out agreement when they first enroll.*	*N/A*	*Yes*	*N/A*	*Yes, as long as they meet all the underwriting requirements and guidelines.*	*To be determined. Contact your Word & Brown representative*	*Yes—Employer is responsible to ensure they are in compliance*
Will they need to prove compliance with IRS code 105(h) or sign a document indicating they do comply?	*N/A*		*N/A*	*No*	*N/A*	*No, but underwriting has the right to request any documents to validate compliance*	*N/A*	*No*

† *The Affordable Care Act (ACA) requires group health plans to comply with IRS code 105(h) which prohibits discrimination in favor of highly compensated employees. After reviewing the comments submitted in response to proposed regulations, the IRS postponed implementation of this portion of ACA until they release further guidance. In anticipation of that guidance, some health plans already have decided to no longer accept carve-outs. Once this guidance is published the responses outlined above may change. Word & Brown will keep focused on this important issue and update you promptly regarding any changes.*

UNDERWRITING APPOINTMENT REQUIREMENTS - ANCILLARY

	Ameritas	BEST Life and Health Insurance Company	California Dental Network	Camden	ChoiceBuilder®	Delta Dental	Delta Dental (MWG)	Guardian	Humana
Licensing Required?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*
Will the Carrier hold the approval?	*No—but commissions will not be paid until appointed*	*No*	*No*	*No*	*No*	*N/A*	*No—but commissions will not be paid until appointed*	*No, but commissions will not be paid until approval*	*No*
Requirements	*W-9 is required* *Copy of license is required* *DOI printout accepted*	*W-9 is required* *Copy of license is required* *DOI printout accepted*	*W-9 is required* *Copy of License is required* *DOI printout accepted*	*Copy of License is required* *DOI printout accepted*	*W-9 is required* *Will verify license on the DOI* *Broker Licensing Packet*	*N/A*	*W-9 is required* *Carrier will verify license on the DOI* *Proof of E&O is required* *Carrier will backdate commissions on a case by case basis*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O required*	*W-9 is required* *Copy of license is required* *DOI printout accepted*
Check appointment status	*group_licensing@ameritas.com*	*cs@bestlife.com*	*rfps@caldental.net*	*phil@thecamden.com*	*commissions@choicebuilder.com*	*None*	*appointmentsandcommissions@morganwhite.com*	*Licensing and appointment is performed online. Please contact local Guardian representative for verification.*	*agencymgt@humana.com*
Ok To Send Licensing Without Case Submission?	*Appointment paperwork can be submitted, but will not be processed until group is sold*	*Yes*	*Yes*	*Yes*	*Yes*	*N/A*	*Yes*	*Yes*	*Yes*

UNDERWRITING APPOINTMENT REQUIREMENTS - ANCILLARY

	Liberty Dental	Lincoln Financial Group	MetLife	Nippon Life Benefits	Principal	Reliance Standard	SmileSaver/ MetLife DHMO	Unum	Vision Plan of America	VSP
Licensing Required?	*Yes*	*Yes*	*Yes*	*Yes*	*The marketer must hold the applicable State License for product being sold. Appointment will be processed when business received*	*Yes*	*Yes*	*Yes*	*No*	*Yes*
Will the Carrier hold the approval?	*No*	*No*	*Yes*	*No—but commissions will not be paid until appointed*	*Yes*	*No—but commission will not be paid until appointed*	*No—but commission will not be paid until appointed*	*Yes*	*No*	*No—but commission will not be paid until appointed*
Requirements	*W-9 is required* *Copy of license is required* *DOI printout accepted*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O required*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O required*	*N/A*	*N/A*	*W-9 is required* *Copy of license is required* *DOI printout accepted*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O required*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O required*	*Copy of license is required* *DOI printout accepted*	*W-9 is required* *Copy of license is required* *DOI printout accepted*
Check appointment status	*ClientServices@libertydentalplan.com*	*bplicensing@lfg.com*	*clr_institutional@metlife.com*	*continuingrelations@nipponlifebenefits.com*	*licandappt@exchange.principal.com*	*pdewald@ameritas.com*	*Broker_Change@MetLife.com*	*AskUnum@unum.com 800-633-7491*	*phillip@visionplanofamerica.com*	*asca@vsp.com*
Ok To Send Licensing Without Case Submission?	*Yes*	*Yes*	*Yes - via email*	*No*	*Appointment paperwork can be submitted, but will not be processed until group is sold*	*Yes*	*Yes - via email*	*Yes*	*Yes*	*Yes*

UNDERWRITING APPOINTMENT REQUIREMENTS - MEDICAL

	Aetna	Anthem Blue Cross	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Chinese Community Health Plan	E.D.I.S.	Health Net	Kaiser Permanente*
Licensing Required?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Will the Carrier hold the approval?	*No*	*Yes* *Case can be approved with the GA as the broker. Once agent is appointed, the GA will add the agent*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*Yes*
Requirements	*W-9 is required* *Copy of License is required* *Proof of E&O is required* *Carrier accepts appointment paperwork without case submission* *Carrier can backdate commissions, as long as appointment is secured within 14 days from the effective date*	*W-9 is required* *License is verified with the DOI* *Proof of E&O is required* *Carrier accepts appointment paperwork without case submission* *Carrier cannot pay an agent for a month that they did not have an appointment*	*Agent must be appointed prior to the effective date* *W-9 is required* *Copy of License is required* *Proof of E&O is required* *Carrier accepts appointment paperwork without case submission* *Carrier will not backdate commissions*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O is required*	*W-9 is required* *Will verify license on the state website* *Proof of E&O is required* *Accepts appointment paperwork without case submission*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O is required*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O is required*	*W-9 is required* *Carrier will verify license on the DOI* *Proof of E&O is required* *Carrier will backdate commissions on a case by case basis*	*W-9 is not required* *Copy of license is required* *Proof of E&O is required* *Carrier accepts appointment paperwork without case submission* *Carrier will not backdate commissions*
Check appointment status	*LAAU@ aetna.com*	*ga.support@ anthem.com*	*producerserviceappointments@ blueshield.ca*	*calcpahealth@ calcpahealth.com*	*commissions@ calchoice.com* *Finance Customer Service: 714-567-4390*	*brokers@ cchphealthplan. com*	*Call Broker Services at 888-886-7973*	*broker. contracting@ healthnet.com*	*bcs_ca_ docadministration@ kp.org*
Ok To Send Licensing Without Case Submission?	*Yes*	*Yes*	*Yes*	*No*	*Yes*	*Yes*	*Yes*	*No*	*Yes*

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UNDERWRITING APPOINTMENT REQUIREMENTS - MEDICAL

	MediExcel Health Plan	National General	Oscar	Sharp Health Plan	SIMNSA Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
Licensing Required?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Will the Carrier hold the approval?	*No*	*Yes*	*No*	*No—but commission will not be paid until completed.*	*Yes*	*No, but commissions will not be paid until the broker has been appointed.*	*Yes*	*No—but commission will not be paid until completed*
Requirements	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O is required* *MediExcel/Agent Broker Contract*	*W-9 is required* *DOI printout accepted*	*W-9 is not required* *Copy of license is required* *Proof of E&O is required*	*W-9 is required* *Copy of license is required* *Proof of E&O is required* *Carrier does not need appointment paperwork with case submission* *Carrier will not backdate commissions*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Signed solicitors agreement on file*	*Visit www.sutterhealthplus.org/brokerpartner/prospective-brokers for requirements or send an email to the Broker Services Department at shpbroker@sutterhealth.org.*	*W-9 is not required* *Copy of license is required* *Proof of E&O is not required* *Carrier accepts appointment paperwork without case submission*	*W-9 is required* *Copy of license is required* *DOI printout accepted* *Proof of E&O is required* *Carrier accepts appointment paperwork without case submission*
Check appointment status	*sales@mediexcel.com*	*sflicensing@ngic.com*	*www.hi.oscar.com/brokers*	*ifpsales@sharp.com*	*Bmontalbo@simnsa.com*	*Brokers can check their appointment status by sending an email to shpbroker@sutterhealth.org.*	*appointment_credentialing@uhc.com*	*WHASales@westernhealth.com*
Ok To Send Licensing Without Case Submission?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*Yes - via email*	*Yes*

BILLING CYCLES

Carrier	Date of Billing	Due Date	Termination Date
Aetna	*15th of the prior month*	*1st of the month*	*End of the month*
Aetna 15th Effective Date	*1st of the month*	*15th of the month*	*15th of the following month*
Anthem Blue Cross	*1st of the prior month*	*1st of the month*	*Any time within the month of termination before the end of the month.*
Blue Shield of California	*15th of the prior month*	*1st of the month*	*End of the month*
Blue Shield of California 15th effective date†	*1st of the month*	*15th of the month*	*15th of the following month*
CalCPA Health	*7-10th of the prior month*	*1st of the month*	*30 days after due date*
CaliforniaChoice®	*1st business day of the month prior*	*20th of the month prior*	*Last business day of the month*
Chinese Community Health Plan	*15th of the prior month*	*Last day of the month*	*30 days after due date*
E.D.I.S.	*25th of the prior month*	*10th of the month*	*End of the month*
Health Net	*Assigned date by account rep (usually within the first 3 weeks of the prior month)*	*1st of the month*	*End of the month*
Health Net 15th effective date†	*Determined by Account rep*	*Determined by Account rep*	*Determined by Account rep*
Kaiser Permanente*	*10th of the month prior*	*1st of the month*	*30 days after due date*
MediExcel Health Plan††	*10th day of the prior month*	*1st day of the month*	*Last day of the month*
National General	*10th of the month*	*Month end*	*30 day grace period after the due date*
Oscar	*15th of month*	*1st of month*	*First payment: 10th of month Subsequent payments: 30th of month*
Sharp Health Plan	*25th of the month*	*25th of the month (ex. January premium due on December 25th).*	*1st day of the month following the 30 day grace period*
SIMNSA Health Plan	*18th of the month*	*1st of the month*	*Last day of the month*
Sutter Health Plus	*1-7th of the prior month*	*1st of the month*	*At least 30 days after the due date*
UnitedHealthcare	*HMO Standalone 10th of the month: group will receive by the 2nd week of the month.* *PPO or Multi-Option: Call your Word & Brown representative*	*1st of the month*	*End of the month*
Western Health Advantage	*10th of the prior month*	*Last day of the month prior to the coverage month*	*30 days after the due date*

† *These carriers will only offer 15th of the month effective dates if they are coming off a group plan that ends on the 15th.*
†† *Late fees apply for payments received 10 days after the due date.*

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Minimum Wage $12.00 Employers with 1-25 employees					
Full-Time Payroll			**Part-Time Payroll**		
	Hours Worked	Amount Earned		Hours Worked	Amount Earned
Weekly	30	$ 360.00	Weekly	20	$ 240.00
Bi-Weekly	60	$ 720.00	Bi-Weekly	40	$ 480.00
Semi-Monthly	65	$ 780.00	Semi-Monthly	43.334	$ 520.01
Monthly	130	$ 1,560.00	Monthly	86.667	$ 1040.00
Quarterly	390	$ 4,680.00	Quarterly	260	$ 3,120.00

Minimum Wage $13.00 Employers with 26+ employees					
Full-Time Payroll			**Part-Time Payroll**		
	Hours Worked	Amount Earned		Hours Worked	Amount Earned
Weekly	30	$ 390.00	Weekly	20	$ 260.00
Bi-Weekly	60	$ 780.00	Bi-Weekly	40	$ 520.00
Semi-Monthly	65	$ 845.00	Semi-Monthly	43.334	$ 563.34
Monthly	130	$ 1,690.00	Monthly	86.667	$ 1,126.68
Quarterly	390	$ 5,070.00	Quarterly	260	$ 3,380.00

ANCILLARY – LENGTH OF TIME IN BUSINESS REQUIREMENTS

Carrier	Dental	Vision	Life	Disability (STD, LTD)
aetna™	Start-Ups are eligible with minimum 2 weeks of consecutive payroll	No special requirements	Not offered	Not offered
Anthem BlueCross	Start Up form, same as medical	Start Up form, same as medical	Start Up form, same as medical	Must be in business at least 1 year
blue of california	Start Up form, same as medical	Start Up form, same as medical	Start Up form, same as medical	Not offered
ChoiceBuilder®	Long enough to be able to provide payroll if requested, minimum 2 months. Exceptions can be made	Same as dental	Same as dental	Not offered
DELTA DENTAL® with VSP	No minimums	No minimums	Not offered	Not offered
Guardian®	No minimums	No minimums	No minimums	LTD – groups in business less than 2 years need UW review
Health Net®	Same as medical	Same as medical	Same as medical	Not offered
Humana	No minimums	No minimums	No minimums	Not offered
MetLife®	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups
Principal℠	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups	Group must be in business at least 1 year, no start-ups
UnitedHealthcare®	Same as medical	Same as medical	Same as medical	Not offered in CA
unum®	Group must be in business at least 2 years, however exceptions can be made with "New Business Questionnaire"	Group must be in business at least 2 years, however exceptions can be made with "New Business Questionnaire"	Group must be in business at least 2 years, however exceptions can be made with "New Business Questionnaire"	Group must be in business at least 2 years, however exceptions can be made with "New Business Questionnaire"
vsp®	Not offered	No requirements	Not offered	Not offered

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CANNABIS INDUSTRY CARRIER ACCEPTANCE

Carrier	Requirements
aetna™	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business, personal checks are acceptable in lieu of business check Cashier's checks with PSUID and payment support documentation would also be acceptable in lieu of business check
Anthem BlueCross	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business, personal checks or cashier's checks are acceptable in lieu of business check
blue of california	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business cashier's check or money orders are acceptable in lieu of business check
CaliforniaChoice® Your Health. Your Choice.®	Yes Group needs to meet all eligibility and participation requirements Group's business license from the city in which they operate is acceptable in lieu of business check requirement Due to the nature of business, premium checks can be paid from any account Cashier's checks are also acceptable in lieu of business check
ChoiceBuilder®	Yes Group needs to meet all eligibility and participation requirements Must present an eligible SIC code Due to the nature of business, personal checks or cashier's checks are acceptable in lieu of business check
DELTA DENTAL® A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION	Yes Group needs to meet all eligibility and participation requirements Must present an eligible SIC code Due to the nature of business, personal checks or cashier's checks are acceptable in lieu of business check with a letter of explanation
Guardian®	No Guardian will not write a Cannabis Industry
Health Net®	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business, personal checks specifically from the owner's checking account is acceptable in lieu of business check
KAISER PERMANENTE®	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business, personal checks are acceptable in lieu of business check

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CANNABIS INDUSTRY CARRIER ACCEPTANCE

Carrier	Requirements
MetLife®	No MetLife will not write a Cannabis Industry
Nippon Life Benefits®	No Nippon Life Benefits will not write a Cannabis Industry
Principal℠	No Principal will not write a Cannabis Industry
UnitedHealthcare®	Yes Group needs to meet all eligibility and participation requirements Due to the nature of business, personal checks specifically from the owner's checking account is acceptable in lieu of business check
unum®	No Unum will not write a Cannabis Industry

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COMMON OWNERSHIP/AFFILIATED COMPANIES

Carrier	Guidelines
aetna™	Groups who have more than one business with different TINs may be eligible to enroll as one group if the following are met: • One owner has controlling interest of all businesses to be included • Companies that are affiliated and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer • All groups filed under one combined tax return are considered one group • There are 100 or fewer employees in the combined groups • Business with equal controlling interest may be considered if the owners of the company designate an individual to act on behalf of all the groups • A completed Common Ownership form must be submitted • Underwriting reserves the right to final underwriting review and may consider common ownership on a case-by-case underwriting exception
Anthem BlueCross	Companies that are affiliated and eligible to file a combined tax return for purposes of state taxation shall be considered one employer A letter from the employer's CPA which states the groups are eligible to file consolidated tax returns is required Common ownership groups must meet the definition of a small employer when combined
blue of california	Copies of Articles of Incorporation/Partnership Agreements are required for each group Common ownership groups must meet the definition of a small employer when combined
CaliforniaChoice® Your Health. Your Choice.®	Each company must share a minimum of 50% common ownership Companies must have a related industry (The groups would be able to file payroll taxes jointly) The total number eligible for all combined groups may not exceed 100 Completed Common Ownership Statement Proof of related industries may be required by the Underwriter
Health Net®	Small employers qualified to enroll as a single employer are required to submit a letter from a CPA certifying how they are eligible The CPA must not be an owner or employee of the groups seeking coverage The letter must be on CPA letterhead and it must explicitly state how the groups are eligible to enroll under a single policy Allowable reasons for how common ownership groups are eligible to enroll under a single policy: • Affiliated companies that are eligible to file a combined tax return for state taxation • Controlled groups of corporations • Trades and businesses, whether or not incorporated, under common control • Affiliated service groups Common ownership groups must meet the definition of a small employer when combined
KAISER PERMANENTE®	Business entities that are affiliated and eligible to file a combined tax return for purposes of state taxation will be considered 1 employer and must apply as 1 employer Common ownership groups must meet the definition of a small employer when combined
UnitedHealthcare®	Copies of the filed/stamped Statement of Information reflecting all officer/owners, or signed/dated Partnership Agreements listing all partners' names A letter from the employer's CPA stating that all business entities are eligible to file a combined tax return Submission of a completed and signed Common Ownership Certificate form

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HUSBAND & WIFE GROUPS

Carrier	Will the carriers write a Husband & Wife Group?
aetna™	No Husband & Wife groups are not eligible for coverage
Anthem BlueCross	No Husband & Wife groups are not eligible for coverage
blue of california	Yes Blue Shield will accept Husband & Wife groups as long as both are not owners One of the spouses must be a W2 employee on payroll and not an owner The group cannot be a Sole Proprietor or Partnership Group must be an S-Corporation, C-Corporation or an LLC
CaliforniaChoice® Your Health. Your Choice.®	No Husband & Wife groups are not eligible for coverage
Health Net®	No Husband & Wife groups are not eligible for coverage
KAISER PERMANENTE®	Yes Kaiser will accept Husband & Wife groups Both Husband & Wife may be owners as long as at least one of the spouses is also a W2 employee on payroll The group cannot be a Sole Proprietor or Partnership Group must be an S-Corporation, C-Corporation or an LLC
UnitedHealthcare®	No Husband & Wife groups are not eligible for coverage

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Carrier	Requirements
aetna™	New Hire rates will be based on the member's age at the member's enrollment date
Anthem BlueCross	New Hire rates will be based on the member's age at the member's enrollment date
blue of california	New Hire rates will be based on the member's age at the member's enrollment date
CaliforniaChoice® Your Health. Your Choice.®	New Hire rates will be based on the member's age at the member's enrollment date
COVERED CALIFORNIA	New Hire rates will be based on the member's age at the group's effective date
健華人計保 CCHP Health Plan	New Hire rates will be based on the member's age at the member's enrollment date
Health Net®	New Hire rates will be based on the member's age at the group's effective date
KAISER PERMANENTE®	New Hire rates will be based on the member's age at the group's effective date
Nippon Life Benefits®	New Hire rates will be based on the member's age at the member's enrollment date
Sutter Health Plus Your Health Plan	New Hire rates will be based on the member's age at the member's enrollment date
UnitedHealthcare®	New Hire rates will be based on the member's age at the member's enrollment date
Western Health Advantage	New Hire rates will be based on the member's age at the member's enrollment date

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NO DE9C PROMOTIONS/GUIDELINES

Carrier	Quarterly Wage Report/DE9C not required for:
aetna™	**Guideline:** Groups of 6+ enrolled with prior coverage
Anthem BlueCross	**Promotion:** Groups of **6+ enrolled through 12/15/2020 effective dates** Copy of last month's prior carrier bill is required for all products selected Excludes virgin groups New groups without prior coverage will need to submit DE9C or payroll records Payroll records are required for employees not listed on the prior carrier bill
blue of california	**Promotion:** Groups of 5-95 FT/FTE that have 5-95 eligible employees do not require a DE9C. Owners do not qualify towards the employee count Underwriting reserves the right to request the wage and tax information (DE9C, payroll) whenever necessary to determine eligibility DE9C may be requested for groups with employees 65+ years old enrolling If a group is enrolling with Out Of State employees, companywide payroll may be requested to confirm 51% eligible are in California
CaliforniaChoice® Your Health. Your Choice.®	**Promotion:** Groups of 6+ medically enrolling employees The most recent prior carrier bill is required Employees that are enrolling and are not listed on the prior carrier bill will require one full run of payroll showing eligible hours and wages Groups with a lapse of coverage of more than 3 months are not eligible
Health Net®	**HMO Package through the end of 2020** Quarterly Wage Report/DE9C not required for groups of **6+ enrolled through the end of 2020** 6+ enrolled required. No further participation requirement Participation Attestation Form, Prior Carrier Bill and Waivers are not required Virgin Groups are eligible The HMO package is separate from the Enhanced Choice A and B packages Mix and Match any plans from the HMO networks HSP and PPO plans do not qualify for this promotion
KAISER PERMANENTE®	**Promotion:** Quarterly Wage Report/DE9C not required for **6 or more enrolled with no end date** Business Documentation required (example: business license/SOI) Start Up groups and groups leaving a PEO do not qualify for this promotion
UnitedHealthcare®	**Guideline:** Groups of **10+ eligible employees** Completed and Signed Participation Certification Form is required

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OWNER ONLY GROUPS

Carrier	Will the carriers write an Owner Only Group?
aetna™	No Aetna will not write a group without at least 1 non-owner W2 employee
Anthem BlueCross	Yes Anthem will accept Owner Only groups as long as the groups' business entity is a type of Corporation such as LLC, S-Corp or C-Corp At least 2 eligible owners are required
blue of california	No Blue Shield will not write a group without at least 1 non-owner W2 employee
CaliforniaChoice® Your Health. Your Choice.®	No CaliforniaChoice® will not write a group without at least 1 non-owner W2 employee
Health Net®	No Health Net will write **Officer Only** groups as long as the group's business entity is a type of Corporation such as LLC, S-Corp or C-Corp At least 2 eligible officers are required and at least one of the officers may not be a shareholder and must be listed on the DE9C
KAISER PERMANENTE®	Yes Kaiser will write Owner Only groups as long as the group's business entity is a type of Corporation such as LLC, S-Corp or C-Corp At least one owner must be a W2 employee who will appear on DE9C with eligible wages Group may consist of only 1 eligible W2 owner
UnitedHealthcare®	Yes UnitedHealthcare will accept Owner Only groups as long as the groups' business entity is a type of Corporation such as LLC, S-Corp or C-Corp At least 2 eligible owners are required

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PARTICIPATION & ALONGSIDE GUIDELINES

Carrier	Standalone	Alongside Another Carrier
aetna™	1-4 enrolled employees: 65% through 12/31/2020 5+ enrolled employees: 25% through 12/31/2020	25% participation and a minimum of 5 employees enrolling required for groups offering another carrier's HMO plan
Anthem BlueCross	1-4 enrolled employees: 65% participation through 12/15/2020 effective dates 5+ enrolled employees: 25% participation through 12/15/2020 effective dates	Employees covered by the same employer on another group policy are not considered a valid waiver Another carrier's HMO or PPO plans can be sold alongside Anthem as long as Anthem receives the required participation
blue of california	70% participation for mirror plans 65% participation for off exchange plans 25% participation for off exchange plans available to groups of 5+ enrolling through January 31, 2021 0% participation for groups selecting Trio HMO only and Tandem PPO only plans effective October 1, 2020 with no end date Applies to Specialty Products	Only one major medical carrier is allowed to be written alongside Blue Shield. Health exchanges are not eligible. MediExcel or SIMNSA can be written alongside as a third carrier The Mirror Package for Small Business cannot be offered alongside another carrier. At least 25% of the total number of eligible employees must enroll with no fewer than 5 enrolled. Blue Shield must be the sole carrier for dental, vision and life plans Employees covered by the same employer on another group policy are not considered a valid waiver
CaliforniaChoice® Your Health. Your Choice.®	1-2 eligible employees:100% participation 3+ eligible employees: 70% participation	Cannot be written alongside another carrier
Health Net®	Enhanced Choice A package: 66% for 1-5 and 50% for 6+ eligible employees Enhanced Choice B package: 66% for 1-5 and 35% for 6+ eligible employees No participation requirement for Salud Package with minimum of 2 enrolled through the end of 2020 HMO Package: No participation or Participation Attestation Form required with 6+ active enrolling employees through the end of 2020	Another carrier's HMO or PPO plans can be sold alongside Health Net as long as Health Net receives the required participation Employees covered by the same employer on another group policy will not be considered a valid waiver on the Enhanced Choice A & Enhanced Choice B plans
KAISER PERMANENTE®	50% of eligible employees must be covered by a group plan	A minimum of 1 must enroll with Kaiser Permanente
UnitedHealthcare®	60% participation for all group sizes excluding valid waivers Uniform dependent enrollment is required. All enrolling dependents Product Selection must match for each line of coverage	Choice Simplified Package alongside to staff model carrier: 60% participation between the two carriers with 5 CA employees enrolling with UHC is required Multi-Choice® State Package alongside to staff model carrier: 60% participation with UHC is required Eligible staff-models include: CCHP, KP, MediExcel, Sharp, SIMNSA, Sutter and WHA

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CALIFORNIA SMALL GROUPS CHANGING CARRIERS

PRIOR CARRIER DEDUCTIBLE CREDIT GUIDE

	Aetna	Anthem Blue Cross	Blue Shield of California	CaliforniaChoice®	CalCPA	Chinese Community Health Plan
HMO to HMO Deductible Credit?	Yes	No	Yes	Follow Carrier Rules	No	No
PPO to PPO Deductible Credit?	Yes	Yes	Yes	Follow Carrier Rules	Yes	No
HSA to HSA Deductible Credit?	Yes	Yes	Yes	Follow Carrier Rules	Yes	No
Deductible Credit given from PPO with a deductible to a HMO plan?	As long as group to group there is deductible credit	No	No	Follow Carrier Rules	No	No
Deductible Credit given from HMO with a deductible to a PPO plan?	As long as group to group there is deductible credit	No	No	Follow Carrier Rules	No	No
Out-of-Pocket Max Carryover Credit?	No	No, only on the medical deductible	No	Follow Carrier Rules	Prior carrier calendar year deductible/OOPM may be credited if valid EOB from prior carrier submitted within 60 days of implementation.	No
PEO to PEO Deductible Credit?	No	As long as the previous organization also had Anthem as their carrier and the member is going from like plan to like plan there will be a credit.	No	Follow Carrier Rules	As long as the previous organization also had Anthem as their carrier and the member is going from like plan to like plan there will be a credit.	N/A
Deductible Credit given to groups coming off Trust plans or Large Group?	Yes	Contact your Word & Brown representative	We do give prior carrier medical deductible credit for employees that were covered under the prior employer sponsored group plan (including PEO plans, Trust plans and large group employer plans) in the same calendar year for the similar plan. We give credit for members going from PPO to PPO or HMO to HMO. We do not give credit for members moving from HMO to PPO or PPO to HMO. Typically we do not give deductible credit for prescriptions. However, if the prior medical plan was an HSA plan and the HSA plan deductible included prescription drugs in the medical deductible, we will give deductible credit for it. If the prescription has a separate deducible we do not give deductible credit for it. We do not give deductible credit for Individual plans. We do not give out of pocket maximum credit.	Follow Carrier Rules	Contact your Word & Brown representative	Contact your Word & Brown representative
Prior Carrier Deductible Credit Given?	Yes	Prior carrier calendar year deductible/OOPM may be credited if valid EOB from prior carrier submitted within 60 days of implementation.	Only for groups that have a current group carrier. We only give deductible credit for the employees that were covered under the prior group carrier, for the initial enrollment. New hires are not eligible for deductible credit. We do not give deductible credit for individual plans.	See Plan Specific EOC or COI	Prior carrier calendar year deductible/OOPM may be credited if valid EOB from prior carrier submitted within 60 days of implementation.	No
4th Quarter deductible Credit Given?	No	Yes, they will credit members for the remainder of the calendar year. If a group comes on 11/1 or 12/1 they will receive credit the rest of the year.	No	Contact Carrier Direct	Yes, they will credit them for the remainder of the calendar year. If a group comes on 11/1 or 12/1 they will receive credit the rest of the year.	No
Prior carrier deductible form needed?	No, just the usual EOB, ledger or letter.	There is no form needed. We will need copies of EOB's from prior carrier submitted within 60 days of group implementation.	Yes	Contact Carrier Direct	There is no form needed. We will need copies of EOB's from prior carrier submitted within 60 days of group implementation.	N/A
Where do I send the forms or EOB's?	Must be faxed to 866-474-4040 no later than 90 days after the effective date.	Fax to: 877-237-4519 (Anthem direct)	Fax to 209-371-3049	Contact Carrier Direct	E-mail Calcpahealth@key.insurance.com or fax to 877-237-4519	N/A

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CALIFORNIA SMALL GROUPS CHANGING CARRIERS

PRIOR CARRIER DEDUCTIBLE CREDIT GUIDE

	E.D.I.S.	Health Net	Kaiser Permanente*	MediExcel Health Plan	National General	Oscar
HMO to HMO Deductible Credit?	N/A	No	N/A	N/A	N/A	Oscar accepts deductible credit from any plan type to its EPO plans
PPO to PPO Deductible Credit?	Yes	Yes	N/A	N/A	Yes, on plans with a calendar year deductible.	Oscar accepts deductible credit from any plan type to its EPO plans
HSA to HSA Deductible Credit?	Yes	Yes, but only for PPO HSA	N/A	N/A	Yes, on plans with a calendar year deductible.	Oscar accepts deductible credit from any plan type to its EPO plans
Deductible Credit given from PPO with a deductible to a HMO plan?	N/A	No	N/A	N/A	Yes, on plans with a calendar year deductible	Oscar accepts deductible credit from any plan type to its EPO plans
Deductible Credit given from HMO with a deductible to a PPO plan?	Yes	Yes	N/A	N/A	Yes, on plans with a calendar year deductible	Oscar accepts deductible credit from any plan type to its EPO plans
Out-of-Pocket Max Carryover Credit?	No	No	N/A	N/A	The deductible credited to the plan, will also credit the OOP accumulators	Deductible credit counts toward Max Out of Pocket
PEO to PEO Deductible Credit?	N/A	No	N/A	N/A	N/A	N/A
Deductible Credit given to groups coming off Trust plans or Large Group?	Contact your Word & Brown representative	We will provide prior deductible credit on PPO; The member would just need to provide their most recent EOB at time of claim.	N/A	No, we will not apply deductible credit.	Contact your Word & Brown representative	Oscar will credit prior calendar year deductible if valid EOB from prior carrier is provided within 60 days of group implementation. These accumulators must have been earned under the same employer group's policy and not on an individual policy. Oscar will honor credit only for employees covered under the prior group policy, and for the initial enrollment. New hires not covered on the prior group policy are not eligible for deductible credit. Rx deductible credit is only applicable if it was included in the same medical deductible. Oscar plans are EPO, however deductible credit will be honored from any qualified PPO, HMO or EPO group plan. The new Oscar policy must start the day following the date that the previous coverage was terminated, meaning there can be no lapse in coverage for the group.
Prior Carrier Deductible Credit Given?	Yes	Yes all SBG PPO plans that have deductibles allow for prior carrier deductible credit, as long as this policy is replacing a similar policy that has been issued to the Group Policyholder. This means that members electing a Health Net PPO plan must be replacing a PPO plan with their prior carrier. Members electing HSP plans do not qualify for the prior deductible credit.	No. Kaiser Permanente does not credit members for expenses they incurred toward satisfying deductibles or out of pocket maximums on any medical or dental plan they had before they enrolled in Kaiser Permanente.	N/A	Yes, on plans with a calendar year deductible.	Yes. Valid EOB from prior carrier must be provided within 60 days of group implementation. Oscar will honor credit only for employees covered under the prior group policy, and for the initial enrollment. New hires not covered on the prior group policy are not eligible for deductible credit.
4th Quarter deductible Credit Given?	No	No	N/A	N/A	No	No
Prior carrier deductible form needed?	Yes	No. Claims ledgers or deductible credit letter with the breakdown of the family deductible credits can be given by the previous carrier.	N/A	N/A	For large groups, the transitioning of deductible credits would be smoother if a report were provided.	Yes
Where do I send the forms or EOB's?	underwriting@employerdriven.com	Fax EOB's to 866-848-6715 GA can send to hn_accountServices@healthnet.com	N/A	applications@mediexcel.com	On the address of the ID card.	brokers@hioscar.com (attached as pdf)

*** Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.**

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CALIFORNIA SMALL GROUPS CHANGING CARRIERS

PRIOR CARRIER DEDUCTIBLE CREDIT GUIDE

	Seniors Choice	SIMNSA Health Plan	Sharp Health Plan	Sutter Health Plus	UnitedHealthcare	Western Health Advantage
HMO to HMO Deductible Credit?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	Yes	No
PPO to PPO Deductible Credit?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	Yes	N/A
HSA to HSA Deductible Credit?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	Yes	Yes
Deductible Credit given from PPO with a deductible to a HMO plan?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	No	Only if from a PPO HSA plan to an HMO HSA plan
Deductible Credit given from HMO with a deductible to a PPO plan?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	No	N/A
Out-of-Pocket Max Carryover Credit?	Contact your Word & Brown representative	N/A	No	Contact your Word & Brown representative	No	Deductible credit counts toward OOPM
PEO to PEO Deductible Credit?	Contact your Word & Brown representative	N/A	No	Contact your Word & Brown representative	No	N/A
Deductible Credit given to groups coming off Trust plans or Large Group?	Contact your Word & Brown representative	No, SIMNSA does not cover a prior deductible credit; we do not have a deductible in our plans.				Only if from a PPO HSA plan to an HMO HSA plan
Prior Carrier Deductible Credit Given?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	Yes	Yes, from group HSA to group HSA plan only
4th Quarter deductible Credit Given?	Contact your Word & Brown representative	N/A	No	Contact your Word & Brown representative	No	No
Prior carrier deductible form needed?	Contact your Word & Brown representative	N/A	Yes	Contact your Word & Brown representative	Need an EOB for each employee and dependent seeking credit OR a carrier deductible report if available	Yes
Where do I send the forms or EOB's?	Contact your Word & Brown representative	N/A	Once the form is filled out it can be e-mailed to Customer_service@sharp.com. The most current EOB must accompany this form.	Contact your Word & Brown representative	Ga_Service@uhc.com	WHASales@westernhealth.com or via fax at 916-568-1338, or as instructed during implementation

Carrier	Guideline for staying with a PEO	Guideline for leaving a PEO
In addition to meeting standard Underwriting Guidelines, groups must provide the following:		
aetna™	1-5 enrolling: • Letter from the PEO confirming that they do not offer health coverage • Copy of the PEO contract • Quarterly Wage & Tax Report (DE9C). If DE9C is not available due to the length of time in business at least 6 weeks of companywide payroll to establish group eligibility 6+ enrolling: • Letter from the PEO confirming that they do not offer health coverage • Copy of the PEO contract • If the group does not have current health coverage outside of the PEO: Quarterly Wage & Tax Report (DE9C). If DE9C is not available due to the length of time in business at least 6 weeks of companywide payroll to establish group eligibility • If the group has current health coverage outside of the PEO: No DE9C, payroll or current health coverage bill needed to establish group eligibility	1-5 enrolling: • Copy of the contract termination letter sent from the PEO to the employer verifying the cancellation of the leasing arrangement as well as the date • Copy of the most current quarterly wage report filed by the PEO or at least 1 month of current consecutive payroll 6+ enrolling: • Copy of the contract termination letter sent from the PEO to the employer verifying the cancellation of the leasing arrangement as well as the date • If the group does not have current health coverage: Copy of the most current quarterly wage report filed by the PEO or at least 1 month of current consecutive payroll • If the group has current health coverage: No DE9C, payroll or current health coverage bill needed to establish group eligibility
Anthem BlueCross	Groups that are currently with a PEO are not eligible for coverage	Provide a copy of PEO client invoice billed to the worksite business, which includes names of each employee previously leased to the worksite employer Signed Conditions of Enrollment form will be required Company's first 30 days complete payroll records to be provided within 45 days of the effective date
blue of california	Groups that are currently with a PEO are not eligible for coverage	Copy of the letter sent from the PEO to the client business verifying the cancellation of the leasing arrangement will be required If a copy of a payroll is submitted that separates the formerly leased employees by business location, the group will be considered a qualified group
CaliforniaChoice® Your Health. Your Choice.®	Sub-group's home office must be located in California Statement of Compliance portion of the Employer Application must be signed by an authorized representative of the sub-group, not a PEO representative PEO Sub-Group Letter is required Quarterly Wage & Tax Report (DE9C) or payroll ledger including summary totals for the most current three months	Groups leaving a PEO on the enrollment effective date must provide: • Explanation from the employer with a description and date of the PEO split-off scenario • One week of payroll from the new payroll company with the balance for the month due within 30 days of the effective date Groups that left a PEO prior to the enrollment effective date must provide: • Explanation from the employer with a description and date of the PEO split-off scenario • Payroll under the company (not the PEO) from start to current is required - must be at least one week For both scenarios: If payroll is not equal to one month, group will be approved contingent on the remainder of payroll 1-4 life groups will need at least 4 weeks of payroll prior to the requested effective date for one common-law employee

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Carrier	Guideline for staying with a PEO	Guideline for leaving a PEO
In addition to meeting standard Underwriting Guidelines, groups must provide the following:		
Health Net®	A DE9C or quarterly wage report from the PEO is required if the PEO provides them for its employer groups If the PEO does not prepare a quarterly wage report for each employer, payroll from the PEO may be substituted The quarterly wage report and/or payroll must demonstrate that the group meets the definition of a small employer and that the employees are eligible for coverage	PEO termination letter will be required Provide at least two weeks of acceptable payroll under the company name, not the PEO Proof of prior coverage under PEO will be required
KAISER PERMANENTE®	Groups may only offer coverage outside the PEO. The PEO may not offer Kaiser 1-5 enrolled: • Most recently filed DE9C or 3 months of group's PEO payroll subgroup or 3 months of recent invoices showing PEO, subgroup name, and co-employed individuals • For start-up groups, 2 weeks of the group's PEO payroll subgroup or 2 weeks of recent invoices showing PEO, subgroup name, and co-employed individuals 6+ enrolled: • No DE9C or payroll required	A letter from the group stating it will no longer be leasing employees from the PEO which includes the termination date. Termination date must be prior to requested effective date 1-5 enrolled: 2 weeks of payroll for leased employees from the PEO 6+ enrolled: No DE9C or payroll required
UnitedHealthcare®	PEO may not act as a "co-employer" Groups that use PEO payroll services alone are eligible	Copy of the prior carrier bill from the PEO with employee census confirming prior coverage will be required Provide a copy of the contract termination letter sent from the PEO to the employer that verifies the cancellation of the leasing arrangements as well as the cancellation date Provide at least two weeks of payroll from a legitimate payroll company issued in the name and Tax Identification Number of the individual employer group, not the PEO In the event of a DE9C or payroll is unavailable, groups must provide the following: • Copy of the six weeks of charge back invoices from the PEO to establish AB1672/SB125 • Copy of the PEO Benefit Register or prior carrier bill • Letter from the company owner/officer stating the company has cancelled its contract with the PEO and the effective date of cancellation plus 30 days of payroll records for all employees The employer group must have offered the employees health insurance previously through the PEO

This guide has been created as a quick reference and does not replace the full underwriting guidelines published by each carrier
Please refer to the carrier guidelines for additional information

SPECIAL OPEN ENROLLMENT

Carrier	Guidelines
aetna™	Must be the sole carrier confirmed by an attestation form Must be complete at submission with all requirements in by 12/15 midnight - no exceptions Recertification at renewal: Yes, to ensure group meets the definition of a small employer Ancillary coverage will follow normal guidelines for participation and contribution
Anthem BlueCross	Must be the sole carrier Must be complete at submission with all requirements in by 12/16 by 5 PM Dental/Vision will participate in Special Open Enrollment. Specialty lines must have a minimum of 2 employees enrolled on each specialty line selected Recertification at renewal: No
blue of california	Can be written alongside another carrier's HMO only, another carrier's HMO and MediExcel only, or another carrier's HMO and SIMNSA only Regular underwriting guidelines apply Must be submitted to Blue Shield by 5 PM on 12/31 and approved within 30 days of submission Dental/Vision follow medical. Life does not follow medical Recertification at renewal: At the carrier's discretion
CaliforniaChoice® Your Health. Your Choice.®	Must be the sole carrier Cases must be submitted to CaliforniaChoice on 12/16 by midnight and approved by end of business day on 12/31 Contingent approvals will be allowed Recertification at renewal: At the carrier's discretion Ancillary coverage will follow normal guidelines for participation and contribution
Health Net®	Does not require to be the sole carrier Cases must be submitted to Health Net on 12/16 by 5 PM and must be approved by 5 PM on 1/21/20 Recertification at renewal: At the carrier's discretion Ancillary coverage will follow normal guidelines for participation and contribution
KAISER PERMANENTE®	Does not require to be the sole carrier Cases must be submitted to Kaiser on 12/16 by 5PM Recertification at renewal: Yes, to ensure group meets the definition of a small employer Ancillary coverage will follow normal guidelines for participation and contribution
UnitedHealthcare®	Does not require to be the sole carrier with staff model carrier (can write alongside two staff model carriers) Requires at least 5 CA employees to enroll with UnitedHealthcare if writing alongside another carrier Must be complete at submission with all requirements in by 12/15 at 11:59 PM - no exceptions Recertification at renewal: Yes, to ensure group meets the definition of a small employer Ancillary coverage will follow normal guidelines for participation and contribution
Western Health Advantage	Does not require to be the sole carrier Case must be submitted to Western Health Advantage on 12/15 by midnight – no exceptions Recertification at renewal: Yes, to ensure group meets the definition of a small employer

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START-UP GROUP REQUIREMENTS

Carrier	Requirements
aetna	Groups with 1-19 enrolled employees and groups with no existing health coverage must submit a copy of the most recently filed DE9C. If not available, two consecutive weeks of payroll records are required An existing group that has just hired their first W2 qualifies as a start-up with two weeks of consecutive payroll
Anthem BlueCross	A signed and completed Conditions of Enrollment form is required The company's first 30 days of payroll records must be submitted within the first 45 days of the requested effective date Business Documentation required (example: business license/SOI) An existing group that has just hired their first W2 qualifies as a start-up, including Sole Proprietors and Partnerships
blue of california	Blue Shield will consider Start-Up groups that have been in business and have employed at least one eligible common law W2 employee for less than 6 weeks The W2 employee can be hired on the requested effective date. In this scenario Blue Shield will not accept the group before the date of hire A signed and completed Start-Up Companies/Spin-Off Group Eligibility Statement will be required W4 forms for all W2 employees are required Filed owner documentation linking owner to business is required
CaliforniaChoice® Your Health. Your Choice.®	1-4 enrolling: At least one common law employee must enroll and have 4 weeks of payroll prior to the requested effective date. The other common law employees are required to be on payroll for at least one week on or prior to the effective date (or from start date to current, whichever is greater) If the owner is not on payroll, provide ownership documents 5+ Enrolling Where Majority Enrolling are Common Law Employees: One week of payroll is required for a contingent approval. The remaining payroll to complete one month is contingent If the owner is not on payroll, provide the Owner/Partner form. Ownership documents may be requested at the underwriter's discretion 5+ Enrolling Where Majority Enrolling are Owners: 1 common law employee must be on payroll for 4 weeks prior to the requested effective date If the owners are not on payroll, provide the Owner/Partner forms and applicable owner documents
Health Net®	Groups of 1-5 eligible employees are not eligible for Start-Up. They must be in business for 50% of the prior calendar quarter 6+ enrolling: Requires 4 weeks of payroll with a minimum of 2 weeks prior to the effective date
KAISER PERMANENTE®	Sole Props & Partnerships: Minimum 1 eligible W2 employee, on or before requested effective date and unable to provide 2 weeks of payroll Group must provide Payroll Attestation form at enrollment and follow with 2 weeks of payroll within 45 days of effective date Owners/Partners and their Spouses/Domestic Partners do not count as the eligible employee Corporations & LLCs: Minimum 1 eligible W2 employee, on or before requested effective date and unable to provide 2 weeks of payroll Group must provide Payroll Attestation form at enrollment and follow with 2 weeks of payroll within 45 days of effective date A single owner may count as the eligible W2 employee who will appear on payroll with eligible wages
UnitedHealthcare®	Start-up groups that have been in business for at least 2 weeks are eligible Evidence of time in business must be supported by payroll records. The payroll records must cover the 2 weeks preceding the requested effective date for at least one eligible employee The group must have and maintain business licenses and/or appropriate state filings allowing the company to conduct business in the state of California Owner Only Start-up Groups are not eligible All groups must be true start-ups. An existing group that has just hired their first W2 is not eligible

This guide has been created as a quick reference and does not replace the full underwriting guidelines published by each carrier
Please refer to the carrier guidelines for additional information

Carrier	What is considered a Valid Waiver?	
aetna™	Spousal Group Coverage Parental Group Coverage Enrolling as dependent in the group health plan Individual Coverage	Medicare Medi-Cal TRICARE
Anthem BlueCross	Other Group Coverage Individual Coverage Enrolling as dependent in the group health plan	Medicare Medi-Cal TRICARE
blue of california	Other Group Coverage Individual Coverage Medicare	Medi-Cal TRICARE
CaliforniaChoice® Your Health. Your Choice.®	Other Group Coverage Enrolling as dependent in the group health plan Medicare	Medi-Cal TRICARE
Health Net®	Other Group Coverage Individual Coverage Enrolling as dependent in the group health plan Medicare	Medi-Cal TRICARE
KAISER PERMANENTE®	Other Group Coverage Enrolling as dependent in the group health plan Medicare	Medi-Cal TRICARE
UnitedHealthcare®	Other Group Coverage Individual Coverage Enrolling as a dependent in a group health plan through a different employer	Medicare Medi-Cal TRICARE

This guide has been created as a quick reference and does not replace the full underwriting guidelines published by each carrier
Please refer to the carrier guidelines for additional information

WAITING PERIOD OPTIONS

Carrier	Waiting Period Options
aetna™	First of the month following date of hire First of the month following 30 days from the date of hire First of the month following 60 days from the date of hire
Anthem BlueCross	First of the month following date of hire First of the month following one month from the date of hire First of the month following two months from the date of hire, not to exceed 90 days
blue of california	First of the month following date of hire First of the month following 30 days from the date of hire First of the month following 60 days from the date of hire On the 91st day following the date of hire
CaliforniaChoice® Your Health. Your Choice.®	First of the month following date of hire First of the month following 30 days from the date of hire First of the month following 60 days from the date of hire
Health Net®	First of the month following date of hire First of the month following one month from the date of hire First of the month following 30 days from the date of hire First of the month following 60 days from the date of hire
KAISER PERMANENTE®	Not Applicable
UnitedHealthcare®	First of the month following date of hire First of the month following 30 days from the date of hire First of the month following 60 days from the date of hire

This guide has been created as a quick reference and does not replace the full underwriting guidelines published by each carrier
Please refer to the carrier guidelines for additional information

ONLINE RESOURCES

Tools to Help You Do Your Job Better

Whether you're new to Word & Brown, or you've been partnering with us for years, you may not be aware of all of the online resources we offer to help you serve your clients. **Check them out below.**

Small Group Underwriting Quick Reference Charts

https://ca.wordandbrown.com/resources/Pages/SG-Underwriting-Quick-Reference-Charts.aspx

Participation & Alongside Guidelines
(Effective 7/1/2020)

Husband & Wife Groups
(Effective 6/1/2020)

Special Open Enrollment Window
(Effective 6/1/2020)

No DE-9C Promotions
(Effective 7/1/2020)

New Hire Rating Guide
(Effective 6/1/2020)

PEO Guide
(Effective 6/1/2020)

Owner Only Groups
(Effective 6/1/2020)

Waiting Period Options
(Effective 6/1/2020)

2020 Payroll Guide
(Effective 1/1/2020)

Valid Waivers Guide
(Effective 6/1/2020)

Start-up Groups
(Effective 6/1/2020)

DE-9C Filing Dates Guide
(Effective 12/1/2018)

Common Ownership Guide
(Effective 6/1/2020)

Provider and Rx Formulary Search Instructions

https://ca.wordandbrown.com/resources/Pages/Prov-Directory-Rx-Formulary-Guides.aspx

Small Group Provider Search Request Form (All Medical Carriers)
(Updated 3/2020)

Large Group Provider Search Request Form (All Medical Carriers)
(Updated 1/2020)

Medical Group & IPA Network Comparison Charts

https://ca.wordandbrown.com/resources/Pages/Network-Comparison-Charts.aspx

Northern California
(Effective 1/1/2020)

Orange County
(Effective 1/1/2020)

San Diego
(Effective 1/1/2020)

Los Angeles
(Effective 1/1/2020)

Inland Empire
(Effective 1/1/2020)

Products

https://www.wordandbrown.com/products

CALIFORNIA RATING AREAS

Area	Counties
1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
2	Marin, Napa, Solano, Sonoma
3	El Dorado, Placer, Sacramento, Yolo
4	San Francisco
5	Contra Costa
6	Alameda
7	Santa Clara
8	San Mateo
9	Monterey, San Benito, Santa Cruz
10	Mariposa, Merced, San Joaquin, Stanislaus, Tulare
11	Fresno, Kings, Madera
12	San Luis Obispo, Santa Barbara, Ventura
13	Imperial, Inyo, Mono
14	Kern
15	Los Angeles (906, 907, 908, 910, 911, 912, 915, 917, 918, 935)
16	Los Angeles (900, 901, 902, 903, 904, 905, 913, 914, 916)
17	Riverside, San Bernardino
18	Orange
19	San Diego

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MEDICAL

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CONTACT INFORMATION

Broker Support: BOR changes, renewals and group terminations	*Contact Dedicated Account Client Managers, or submit to nationalSSCSmallGroup@aetna.com*
Broker licensing and appointment information	*866-511-2863, LAAU@aetna.com*
Commissions	*800-622-3435, BrokerComm@aetna.com*
Employer Support	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com*
Adds/Terms	*Additions and Terminations can be processed online at aetna.com/employer. If additional assistance is needed, please contact the enrollment department at enrollmentsgw@aetna.com*
Enrollment Department	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com*
Payments	*Refer to invoice for correct payment mailing address*
Provider Services/Eligibility Verification Prior Carrier Deductible Credit	*888-632-3862 Fax: 859-455-8650 (include new Aetna ID number and a copy of ID card and/or SSN and date of birth)*
Member Support/Bilingual Support	*888-702-3862 (HMO) - option 4 Spanish 888-802-3862 (PPO/Indemnity) - option 4 Spanish*
Pre-Authorization & Pre-Certification Department	*800-333-4432*
Internet Support	*Aetna Navigator and Producer World:1-800-225-3375 Producer World Technical support: 1-866-910-9895*
Cal COBRA Department	*888-595-1542 Fax: 866-651-3120*
Claims	*Refer to Back of Medical ID card for mailing address. Aetna Answer Team: 1-800-343-6101, option 2 or Member Services: 1-866-529-2517 (HMO) & 888-802-3862 (PPO/Indemnity)*
Billing	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com*
Account Services, Eligibility, Release Authorization (for HIPAA Release Forms), Pharmacy Services, Account Service & Membership Accounting Dept., and Producer Services	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com*
To contact by mail, or for payment submission	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com*
Benefits	*Aetna Answer Team: 1-800-343-6101 or WestAAT@aetna.com or Member Services: 1-866-529-2517 (HMO) & 888-802-3862 (PPO/Indemnity)*
Client Management Dept. (for rates and service issues) and Small Group Cancellations/Reinstatements	*Contact Dedicated Account Client Managers, or submit to nationalSSCSmallGroup@aetna.com*
Broker Licensing Department	*Broker Licensing: www.aetna.com 1-866-714-9301, 8 a.m. - 6 p.m. ET Broker Commissions: BrokerComm@aetna.com*

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PROVIDER NETWORKS

HMO Networks	*Full HMO, HMO Deductible, AVN HMO, Basic HMO, AWH HMO Southern*
PPO Networks	*Full MC, PPO, Savings Plus, AWH MC Southern, Open Choice PPO*
EPO Networks	*Elect Choice EPO, AWH EPO Southern*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*Effective 4/1/2020 and beyond, new business case submission will be the 5th of the month for first of the month cases; 20th of the month for 15th of the month cases. If the cutoff date falls on the weekend, the case will need to be submitted by end of day on the Monday following.*
Premium Amount Required for 15th?	*One month*
Applications must be dated within	*Before & within 90 days of requested effective date*
Spouse/Domestic Partner Employees - 1 application or 2?	*Either 1 or 2 applications*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS *(IF APPLICABLE)*

Groups 6+ do not need DE-9C

Groups will go through the Aetna re-verification annually. Aetna sends out the documentation 6 months prior to the effective date directly to the employer.

Dependents who reside separately from the employee and are not in an approved Aetna HMO service area will be enrolled on the subscriber's HMO plan and will need to access care via the selected Primary Care Physician in the subscriber's/family's HMO service area (except for urgent and emergency care).

Effective Date	Submission deadline
1st of the month	*1st of the month*
15th of the month	*15th of the month*

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PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1**
Max. # of employees	*100*	*100*

**AB 1672 group of 2 with one valid waiver due to other group coverage, Medicare or Medicaid*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*Employer may choose from any of the below contribution amounts:* • *At least 50% of the employee-only rate of whichever plan the employee selects; or* • *At least $80; or* • *Actual cost of the plan*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	Promotional relaxed participation through 12/31/20 effective dates:	
	1-4	*5-100*
Employees ◆◆	*65% participation required for four or less subscribers enrolled.*	*25% participation for groups of five or more enrolled subscribers.*
	• *Aetna will allow one other Carrier HMO and/or PPO alongside (excludes EPO plans)* • *Participation with another carrier is not considered a valid waiver*	
Dependents	*N/A*	*N/A*
Non-Contributory		
Employees ◆◆	*100% of eligible employees, excluding valid waivers*	*100% of eligible employees, excluding valid waivers*
Dependents	*N/A*	*N/A*

Those covered by another plan are NOT considered eligible in calculating participation

◆◆ *In order to NOT be considered eligible, the other coverage must be a group plan, , Individual on/off exchange, Medicare or Medicaid. Calculation for participation rounds down, not up. For example, a group of 5 employees on a Contributory Plan requires only 3 applications instead of 4 (5 x 75% = 3.75).*

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COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes—must be full-time employee, have an employer/employee relationship and have workers' comp coverage. Need to submit DE-9C for proof*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes. Only emergency services will be covered outside of USA.*
Is coverage available for out-of-state employees?	*Yes—employees who reside out-of-state will be offered California plans and rates.* *Product availability is based on network availability:* • *Out-of-state employees who reside in an area with an MC network must enroll in an MC plan;* • *Out-of-state employees who reside outside the MC network must enroll in the Open Choice PPO Plan;* • *HMO plans are not available outside California*
Max. percentage of employees residing out-of-state allowed	*Aetna does not have a maximum out-of-state percentage. However, if more than 49% of employees reside outside of CA, group will not be guarantee issue.*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Medical/Durable Medical Equipment Benefit*				■	■	■

†Vendors for Diabetes Equipment: Visit www.aetna.com and click on the "Find a Doctor" link

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Generally under the 4th tier Prescription Drug Benefit*	*Depends on drug**	*Typically through Aetna Specialty Pharmacy*
MC plans	*Generally under the 4th tier Prescription Drug Benefit*	*Depends on drug**	*Typically through Aetna Specialty Pharmacy*
PPO & Indemnity plans	*Generally under the 4th tier Prescription Drug Benefit*	*Depends on drug**	*Typically through Aetna Specialty Pharmacy*

** Check Aetna's Rx formulary at www.aetna.com/formulary*

For Prescription information, refer to comparison chart in the front of this guide.

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

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Anthem BlueCross

CONTACT INFORMATION

Member Support	*Phone 855-383-7248*	*Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007*
Internet Support	*anthem.com/ca*	
Bilingual Support	*ACA members - 855-854-1429 Members on grandmothered plans - 800-627-8797*	
Provider Eligibility Verification	*855-854-1438*	
Claims	*Dental - Customer service, Member services, Claims, Billing - Telephone: 855-854-1429 Hours: 8:00 a.m. to 6 p.m. PST (Monday–Friday)*	*Medical Claims - 855-383-7248 Dental Claims - 888-209-7852 Prime & Complete Dental Claims - 877-567-1804 Vision Claims - 866-723-0515 Life Claims - 800-813-5682 Disability Claims - 800-232-0113*
Pre-Authorization Dept.	*800-274-7767*	
Cal-COBRA Dept.	*Phone: 855-854-1429 Fax: 855-750-2227 Email: small.group@anthem.com Anthem Blue Cross P.O. Box 51011 Los Angeles, CA 90051-5311*	
Small Group Cancellations/Reinstatements	*888-686-9807*	
Billing	*855-854-1429*	
Group Eligibility	*855-854-1429*	
Broker Licensing Dept.	*Broker Services Telephone: 877-304-6470 Email: agent.support@anthem.com Hours: 8:30 a.m. to 5 p.m. PST (Monday–Thursday) 8:30 a.m. to 3 p.m. PST on Friday*	
Producer Service/Commissions	*Broker Services Telephone: 800-678-4466 Email: agent.support@anthem.com Hours: 8:30 a.m. to 5 p.m. PST (Monday–Thursday) 8:30 a.m. to 3 p.m. PST on Friday*	
Adds/Terms	*855-854-1429 Email: small.group@anthem.com*	
Billing	*Phone 855-854-1429 Fax 855-750-2227*	*Anthem Blue Cross P.O. Box 51011 Los Angeles, CA 90051-5311*
Underwriting Dept.	*Small Group Underwriting address Anthem P.O. Box 9042 Oxnard, CA 93031-9042*	*Small Group Underwriting New business: newsguwca@anthem.com Existing business: sguwca@anthem.com New business telephone: 855-239-9251 New business fax: 866-795-5442 Existing business fax: 877-363-9126*
Pharmacy Services Dept.	*Pharmacy Member Services: 833-253-4446 Pharmacy retail: Phone 866-297-1013 Pharmacy home delivery: Phone 888-452-4357 Hearing-Impaired: Phone 800-899-2114*	
Administrator	*800-627-8797*	
Small Group Premium Payments	*Enrollment and Billing Phone 855-854-1429 Fax 855-750-2227 Email: small.group@anthem.com*	
Claims HMO/POS	*Phone 800-627-8797 Fax 877-287-1262*	
Tax ID Number	*953760980*	

Anthem BlueCross

PROVIDER NETWORKS

HMO Networks	*Traditional HMO Network (CaliforniaCare); SELECT HMO Network, Priority Select HMO Network (Limited counties)*
PPO Networks	*Prudent Buyer PPO Network; SELECT PPO Network*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*On the 1st or 15th of the month*
Premium Amount Required for 15th?	*Yes*
Applications must be dated within	*Anthem Blue Cross will accept new group submissions by the fifth working day of the month when the application is for the first of the month effective date. If the application is made for a 15th of the month effective date, paperwork must be received by the 12th calendar day of the month. Applications need to be dated within 60 days of the effective date.*
Spouse/Domestic Partner Employees - 1 application or 2?	*Dependents should be added with the Subscriber onto the Employee application.*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*Anthem does not require them to have Workers' compensation.*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Contact your Word & Brown representative*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

Please see plan specific EOC.

Anthem BlueCross

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100*	*100*

Minimum Employer Contribution

	Group Size		
	1-100		
	Traditional Option	*Fixed-Dollar Option*	*Percentage and Plan Option*
Employees	*50%*	*A fixed-dollar amount $100 or greater (in $5 increments)*	*50%*
For Dependents	*N/A*	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	1-14 eligible employees	*15 or more eligible employees*
Employees	*†70%*	*†50%*
Dependents	*N/A*	*N/A*
Non-Contributory		
Employees	*100%*	*100%*
Dependents	*N/A*	*N/A*

*† For Q3 through 9/15/18 effective dates **30% participation is available for five (5) or more enrolled employees***

Anthem BlueCross

Anthem BlueCross

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Commission-only employees are not eligible.*
Are 1099 employees allowed?	*Employees compensated on a 1099 basis are not eligible.*
Are employees covered if traveling out of USA?	*With the Blue Cross Blue Shield (BCBS) Global Core Program (formerly BlueCard Worldwide Program), our PPO members who need care when they're traveling can enjoy the benefits of their Anthem Blue Cross membership anywhere in the United States (subject to the terms and payment provisions of their Anthem Blue Cross health plan). BCBS Global Core offers access — at significant savings — to doctors and hospitals outside California that participate in other Blue Cross plan networks. The program gives members access to more than 70% of doctors and 80% of hospitals in America. In addition to cost savings, BCBS Global Core offers the security of access to quality health care, wherever our PPO members travel in the United States. To locate a BCBS Global Core participating provider, members can call 1-800-810-BLUE (2583).*
Is coverage available for out-of-state employees?	*Employees who live outside California may only be eligible for PPO plans in the Statewide Prudent Buyer Network and Select PPO Network. Approved out-of-state employees will be charged an area-rate based on the location of the employer's place of business.*
Max. percentage of employees residing out-of-state allowed	*At least 51% of all eligible employees must be employed in California.*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			■
Diabetes Care Benefit				■	■	■

**Subject to medical deductible if plan has one, and coinsurance.*

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans**	*Usually under the Prescription Drug Benefit. For additional information, please see Plan Specific EOC.*	*Yes, for most self-injectable Specialty medications. A Pre-authorization is required.*	*Yes, usually self-injectable Specialty medications have to be procured from IngenioRx Specialty Pharmacy. This is not a mail order pharmacy per se but rather a Specialty pharmacy that used mail to ship the drugs. For additional information, see Plan Specific EOC.*
PPO plans	*Usually under the Prescription Drug Benefit. For additional information, please see Plan Specific EOC.*	*Yes, for most self-injectable Specialty medications. A Pre-authorization is required.*	*Yes, usually self-injectable Specialty medications have to be procured from IngenioRx Specialty Pharmacy. This is not a mail order pharmacy per se but rather a Specialty pharmacy that used mail to ship the drugs. For additional information, see Plan Specific EOC.*
HSA plans	*Usually under the Prescription Drug Benefit. For additional information, please see Plan Specific EOC.*	*Yes, for most self-injectable Specialty medications a Pre-authorization is required.*	*Yes, usually self-injectable Specialty medications have to be procured from IngenioRx Specialty Pharmacy. This is not a mail order pharmacy per se but rather a Specialty pharmacy that used mail to ship the drugs. For additional information, see Plan Specific EOC.*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

Anthem BlueCross

blue of california

CONTACT INFORMATION

Member Support	*HMO and PPO: 888-319-5999*
Internet Support	*www.blueshieldca.com*
Bilingual Support	*888-319-5999, option 9*
Provider Eligibility Verification	*HMO and PPO: 888-319-5999*
Claims	*Fax 209-371-3049*
Pre-Authorization Dept.	*HMO and PPO: 888-319-5999* *Physicians: 800-541-6652*
Cal-COBRA Dept.	*800-228-9476* *Fax 916-350-7480*
Small Group Cancellations/ Reinstatements	*Fax 209-367-6369* *email: small.group@blueshieldca.com*
Group Eligibility	*800-325-5166*
Broker Licensing Dept.	*Fax: 209-371-5835* *email: producer.services@blueshieldca.com*
Producer Service/Commissions	*800-559-5905* *Fax: 209-371-5835* *Email: producer.services@blueshieldca.com*
Adds/Terms	*Fax: 855-808-8598* *Email: small.group@blueshieldca.com*
Billing	*800-325-5166*
Underwriting Dept.	*Email: sguw@blueshieldca.com*
Pharmacy Services Dept.	*800-535-9481*
Administrator	*Blue Shield New Business* *3021 Reynolds Ranch Pkwy.* *Lodi, CA 95240*
Small Group Premium Payments (for existing groups only)	*Blue Shield* *PO Box 749415* *Los Angeles, CA 90074-9415*
Claims HMO/POS	*Attn: Claims Department* *P.O. Box 272540* *Chico, CA 95927-2540*
Tax ID Number	*94-0360524*

blue of california

PROVIDER NETWORKS

HMO Networks	*Access+, TRIO ACO, Local Access+ - based on location of the group*
PPO Networks	*Full, Tandem - based on location of the group*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month unless replacing* *15th of the month available if the group is coming off a 15th of the month effective date. PPO plans only. HMO plans are not allowed.*
Premium Amount Required for 15th?	*Yes—submit one month's premium*
Applications must be dated within	*90 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*Either 1 or 2 applications. This does not count against participation*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS *(IF APPLICABLE)*

The group's DE-9C is required and, if the company officers/owners are not listed on the form, the group must also submit a Sole Proprietor, Partner or Corporation Officer Statement (form C-15923) form for each officer/owner

blue of california

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1**
Max. # of employees	*100*	*N/A*

**AB 1672 group of 2 with one valid waiver due to other group coverage, Medicare or Medicaid*

Minimum Employer Contribution

	Group Size	
	1-100	*1-100* *Defined Contribution*
Employees	*50%*	*A minimum of $100 per employee or a minimum of 50% of the total employee rates*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

Contributory				
	Group Size			
	Single Plan Option and Off Exchange: 1-100	*Single Plan Option and Off Exchange: 1-100 (100% Employer Contribution)*	*Mirror Package: 1-100*	*Mirror Package: 1-100 (100% Employer Contribution)*
Employees	◆◆ *65%†*	◆◆ *100%*	◆◆ *70%*	◆◆ *100%*
Dependents	◆◆ *N/A*	◆◆ *N/A*	◆◆ *N/A*	◆◆ *N/A*
Non-Contributory				
Employees	◆◆ *100%*	◆◆ *N/A*	◆◆ *100%*	◆◆ *N/A*
Dependents	◆◆ *N/A*	◆◆ *N/A*	◆◆ *N/A*	◆◆ *N/A*

◆ *Those covered by another plan are NOT considered eligible in calculating participation. If the employer is offering another carrier alongside BSC, those participating in the other carrier, do count against participation.*

◆◆ *In order to NOT be considered eligible, the other coverage must be a group plan*

† *Only one carrier is allowed to be written alongside a Blue Shield of California Plan. A minimum of 5 and 25% participation must be enrolled on a Blue Shield of California plan. Healthcare exchanges are not eligible for this promotion.*

blue of california

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*No* • *Employees that earn a commission must also earn an eligible hourly wage or salary to be considered eligible for coverage.* • *If we cannot validate that they are making an eligible hourly wage/salary in addition to their commission, that employee would not be considered eligible for coverage.*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes*
Is coverage available for out-of-state employees?	*Yes*—Blue Card program available. HMO plans are not designed to provide coverage for employees who reside outside of California. Employers with employees who reside or work for over six months outside of California should consider a PPO plan* **Except employees living in Hawaii*
Max. percentage of employees residing out-of-state allowed	*For guaranteed issue, a maximum of 49% out-of-state employees allowed. 51% of the employees must live and work in California*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Diabetes Care Benefit*				■*	■*	■*

**Subject to medical deductible if plan has one, and coinsurance.*

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans**	*Prescription Drug Benefit† - if plan has an annual brand Rx deductible, this deductible also applies to home self-administered injectables*	*Most medications and some dosages may require prior authorization*	*Yes - CVS CareMark (800) 378-5697*
PPO plans	*Prescription Drug Benefit† - if plan has an annual brand Rx deductible, this deductible also applies to home self-administered injectables*	*Most medications and some dosages may require prior authorization*	*Yes - CVS CareMark (800) 378-5697*
HSA plans	*Covered under the prescription drug benefit. Medical deductible includes prescription drugs*	*Most medications and some dosages may require prior authorization*	*Yes - CVS CareMark (800) 378-5697*

† *Home self-administered Injectables require prior authorization and are listed in the Blue Shield of California Prescription Drug Formulary. Please note that self-administered injectable copays vary from those for other prescription drugs.*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

CalCPA Health
Health plans for CPAs since 1959

CONTACT INFORMATION

Member Support	*877-480-7923* *calcpahealth@calcpahealth.com*
Provider Eligibility Verification	*Anthem Blue Cross – California Society of CPAs* *888-209-7847*
Bilingual Support	*Anthem Blue Cross – California Society of CPAs* *888-209-7847* *Select prompt # 2-5 based on language preference*
Internet Support	*calcpahealth@calcpahealth.com*
Commissions	*714-567-4390*
Adds/Terms	*Fax 877 237-4519* *calcpahealth@calcpahealth.com*
Billing	*Banyan Administrators: 877-480-7923*
Payments	*Payments can be mailed to:* *Group Insurance Trust* *PO Box 512516* *Los Angeles, CA 90051-0516* *Payments can be made online at:* *www.calcpahealth.com/employers-plan-administrators/pay-online*
Administrator	*Banyan Administrators* *1215 Manor Drive, Suite 200* *Mechanicsburg, PA 17055* *Phone 877-480-7923* *Fax 877-237-4519*
Anthem Blue Cross Customer Service for CalCPA Health Members	*Medical Benefits* — *888-209-7847* *Mental Health Benefits Out-Patient* — *888-209-7847* *Mental Health Benefits/In-Patient* — *800-274-7767* *Express Scripts Pharmacy* — *866-297-1013* *ESI Pharmacy - PPO and HSA* — *877-659-5144* *(member must mention that they are with CalCPA)* *www.express-scripts.com/cacpa* *(Note: In-patient services must be pre-authorized)*
Account Services, Eligibility & Benefits	*Banyan Administrators* *1215 Manor Drive, Suite 200,* *Mechanicsburg, PA 17055* *Phone 877-480-7923* *Fax 877-237-4519*
Precertification and Pre-Authorization Department	*Anthem Blue Cross of CA Utilization Management:* *800-274-7767*
Tax ID Number	*94-2767563*

CalCPA Health
Health plans for CPAs since 1959

PROVIDER NETWORKS

HMO Networks	*Anthem Blue Cross*
PPO Networks	*Traditional Network: Anthem Blue Cross Prudent Buyer* *(Large Group) SELECT Network: Anthem Blue Cross SELECT PPO*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month only*
Premium Amount Required for 15th?	*N/A*
Applications must be dated within	*59 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*If husband and wife are both employees and they enroll separately, they need a W-2 to prove the spouse works there.*

FEES

Enrollment Fee Amount	*None*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*N/A*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

Participation is available to the CA-based owners and employees of accounting firms in public practice or offering general financial services. To obtain and maintain eligibility as an employer, more than 50% of all of the employer's owners (i.e., principals, proprietors, partners, shareholders, or other owners) must be CPA Members of CalCPA, or Associate Members of CalCPA. All CalCPA Members must hold and maintain their CalCPA membership in good standing.

Groups can turn in apps for CalCPA membership with Enrollment. Membership ID# must be included on the Master App.

All employees who work at least 20 or 30 hours per week are eligible to enroll.

CalCPA Health
Health plans for CPAs since 1959

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1**
Max. # of employees	*No max.*	*No max.*

**AB 1672 group of 2 with one valid waiver due to other group coverage, Medicare or Medicaid*

Minimum Employer Contribution

	Group Size
	2+
Employees	*50%*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	2+
Employees	*75%*
Dependents	*N/A*
Non-Contributory	
Employees	*100%*
Dependents	*100%*

CalCPA Health
Health plans for CPAs since 1959

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes—BlueCard (for emergencies only*
Is coverage available for out-of-state employees?	*Yes*
Max. percentage of employees residing out-of-state allowed	*51% of the group's employees must reside in California. Use the employer's ZIP Code for the out-of-state employees on the census to determine rating area*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Durable Medical Equipment Benefit				■	■	■

†Vendors for Diabetes Equipment: Animas Diabetes Care and Apria Health Care. For additional vendors, go to Anthem.com

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO	*Prescription Drug Benefit*	*Yes*	*No*
PPO	*Prescription Drug Benefit*	*Yes for most, but not all*	*No*

**Some injectables may be required to go through the Medco Mail Order Program - call your Word & Brown representative*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

CalCPA Health
Health plans for CPAs since 1959

CaliforniaChoice®
Your Health. Your Choice.®

CONTACT INFORMATION

Member Support	*CaliforniaChoice Customer Service Center* *Anthem Blue Cross* *Health Net* *Kaiser Permanente* *English* *Spanish* *Oscar* *Sharp Health Plan* *Sutter Health Plus* *UnitedHealthcare* *Western Health Advantage*	*800-558-8003* *855-383-7248* *800-361-3366* *800-464-4000* *800-788-0616* *855-672-2755* *800-359-2002* *855-315-5800* *800-624-8822* *888-563-2250*
Bilingual Support	*800-558-8003, Press #9 for Spanish*	
Internet Support	*www.calchoice.com*	
Provider Eligibility Verification	*800-558-8003*	
Broker Services & Commissions	*E-mail: commissions@calchoice.com* *Phone: 714-567-4390*	
Broker of Record Changes	*E-mail: commissions@calchoice.com* *Fax: 714-908-3519* *Phone: 714-567-4390*	
Adds/Terms	*Fax 714-558-8000* *E-mail: memberprocessing@calchoice.com*	
Billing Questions	*800-558-8003*	
Claims	*Contact carriers directly*	
To contact by mail, or for payment submission	*CaliforniaChoice* *721 South Parker, Suite 200* *Orange, CA 92868*	
Tax ID Number	*33-0115986*	

CaliforniaChoice®
Your Health. Your Choice.®

PROVIDER NETWORKS

HMO Networks	*Anthem: CaliforniaCare HMO, Select HMO* *Health Net: CommunityCare;* *Full; WholeCare;* *Salud HMO y Más;* *Kaiser Permanente: Full* *Sharp: Premier; Performance*	*Sutter Health Plus: Sutter Health Plus* *UnitedHealthcare: Advantage,* *Alliance, Focus, SignatureValue* *Western Health: Full*
PPO Networks	*Anthem: Select PPO; Advantage PPO; Prudent Buyer - Small Group*	
EPO Networks	*Anthem: Prudent Buyer - Small Group* *Oscar: Oscar EPO*	

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month only*
Premium Amount Required for 20th?	*Balance Due*
Applications must be dated within	*60 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*Call your Word & Brown representative*
Employee Waiver Cards Required at Enrollment?	*Yes*
Must Brokers Carry Errors & Omissions Insurance?	*Yes*
Does Carrier Offer Open Enrollment?	*Yes*
CaliforniaChoice PPO Guidelines	*COBRA enrollees are not counted toward total group size.* *"Life Only" enrollees are not counted toward total group size.* *"Dental Only" enrollees are not counted toward total group size.*

FEES

Enrollment Fee Amount	*None*		
Type of Enrollment Fee	*N/A*		
Monthly Administrative Fee	*1-8* *$30*	*9-50* *$40*	*51+* *$50*

DEDUCTIBLE CREDIT

Prior carrier deductible credit given?	*See Plan Specific EOC or COI*
4th quarter deductible carry-over credit given?	*Call your Word & Brown representative*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

N/A

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PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100**	*N/A*

* *For plan years commencing on or after January 1, 2016, the definition of small group employer, for purposes of determining employer eligibility in the small employer market, shall be determined using the method for counting full-time employees and full-time equivalent employees set forth in Section 4980H(c)(2) of the Internal Revenue Code. If you need help calculating this you may visit www.calchoice.com and click on ACVA Calculators and use the ACA Full-Time Equivalent calculator.*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*50% of lowest cost plan for each employee*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	1-2	*3-100*
Employees	**100%*	*◆70%*
Dependents	*N/A*	*N/A*
Non-Contributory		
Employees	**100%*	*100% of employees not covered by group insurance and 70% of all employees regardless of other coverage*
Dependents	*N/A*	*N/A*

◆ *Those covered by another plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be a group plan, Champus, Medicare or Medi-Cal*

* *All groups must include at least one medical enrolled employee who is not a business owner or spouse of a business owner*

† *Employer contribution is 100% of employee lowest cost HMO plan or more*

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COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes - commission-only employees are eligible if they have a base a salary that is at least minimum wage and are on the quarterly/annual wage report.*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Only for emergency benefits*
Is coverage available for out-of-state employees?	*Call your Word & Brown representative*
Max. percentage of employees residing out-of-state allowed	*49% (Main office must be located in California)*

DISCOUNTS*, AWARDS & OTHER VALUE-ADDED BENEFITS

Which health care plans offer these discounts, awards and other value-added benefits?

Eyewear & lenses discount	*ABC, HN, KP[1], UHC*
Health club membership or fitness equipment/sporting goods discount	*ABC, HN, KP, SH, UHC, WH*
Health literature, telephone tapes and/or videos (no charge)	*HN, KP, SH, ST, UHC*
available in the following languages	*Spanish (Except ST), Chinese (UHC Only), Korean (UHC Only), Japanese (UHC Only), and Vietnamese (UHC Only)*
Personalized, dynamic online tools on health information	*ABC, ST, UHC, WH*
Home childproofing products discount	*ABC, HN*
Infant car seat discount	*HN*
Infant car seat awarded upon prenatal class completion	*HN*
Nurses 24 hour hotline	*ABC, HN, KP, SH, ST, UHC, WH*
Vitamins and/or herbal supplements discount	*ABC, HN, KP[2], SH, UHC*
Weight control program discount	*ABC, HN, KP[3], SH, UHC*

KEY TO HEALTH CARE SERVICE PLANS OFFERING LISTED PROGRAM:

ABC	*Anthem Blue Cross*
HN	*Health Net*
KP	*Kaiser Permanente*
OH	*Oscar*
SH	*Sharp Health Plan*
ST	*Sutter Health Plus*
UHC	*UnitedHealthcare*
WH	*Western Health Advantage*

* *All CaliforniaChoice® medical members are eligible for discounts on eye exams, lenses, frames, and contacts through the Vision One Eye Care Program administered by EyeMed Vision Care (provided by Ameritas).*

1 *Discounts of frames and lenses available through Kaiser Permanente facilities.*

2 *Discounts on vitamins and herbal supplements available through the "Affinity Program" which links Kaiser Permanente members to Healthy Roads.*

3 *Member must use a Kaiser Permanente weight loss program.*

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PROVIDER INFORMATION	HMO				
	Anthem Blue Cross	**Health Net**	**Kaiser Permanente**	**Sharp Health Plan**	**Sutter Health Plus**
How often can family members change their Primary Care Physician? (PCP)	*Once a month – changes are effective at the beginning of the following month, provided the member is not in the course of treatment or hospitalized and no pending authorizations.*	*Once a month*	*Anytime*	*Once a month*	*Monthly - if made prior to 15th of month, change is effective first of following month*
	NOTE: Each HCSP HMO has their own PCP change approval process				
Can family members each choose a PCP from a different IPA/ Medical Group?	*Yes*	*Yes*	*Yes—from Kaiser Permanente Physicians*	*Yes*	*Yes*
Do plans have these types of programs to speed the specialist referral process in network: Self referral? Express referral?	*Yes – referrals come directly from PCP*	*HMO: Self: Yes— if Rapid Access provider*	*Self: Yes—to OB/GYN and certain other specialties (list varies by region) Express: Yes—referral direct from physician*	*Self: Yes—if available through medical group*	*Members may seek assistance from Member Services or the Nurse Advice Line. Most specialists require a referral only from the PCP, and do not require Prior Authorization. Once PCP enters the referral, it is immediately sent to the specialist office for scheduling.*
Is there an Out-of-Network benefit?	*No*	*No*	*No*	*No*	*No*
PRESCRIPTIONS					
If generic available, and doctor has <u>not</u> indicated "dispense as written," will member receive a generic equivalent rather than a name brand drug?	*Yes*	*Yes—or you must pay brand copay + difference in cost between brand name & generic equivalent*	*Yes*	*Yes*	*Yes - This decision is done at the pharmacy with the financial incentive for the member and pharmacy to go with generics. SHP may require PA for try and fail the generic and will have a higher copay for the brand.*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay?	*No*	*Yes*	*Yes*	*Yes*	*Yes - Tier 3 - Non-Preferred brand name medications are covered at the third tier Cost Share level. These generally have a preferred and often less costly therapeutic alternative at a lower tier.*
Does health plan use Rx formulary?	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
If medically necessary, are non-formulary drugs covered?	*Yes†— non-formulary copay applies* *†Prior authorization may be required for certain medications*	*Yes†— non-formulary copay applies* *†Prior authorization may be required for certain medications*	*Yes—if deemed medically necessary by Health Plan Physician*	*Yes†— non-formulary copay applies* *†Prior authorization may be required for certain medications*	*Yes, with prior authorization, justification required for medical necessity for non-formulary drug*

Prescription copay charts are located on pages 112-113

PROVIDER INFORMATION	HMO		EPO		PPO
	UnitedHealthcare	Western Health Advantage	Anthem Blue Cross	Oscar	Anthem Blue Cross Life and Health Insurance Company
How often can family members change their Primary Care Physician? (PCP)	*Anytime*	*Once a month—changes are effective at beginning of the following month, provided the member is not in the course of treatment or hospitalized and no pending authorizations*	*N/A - PCP selection is not required*	*N/A - PCP selection is not required*	*Anytime—in a PPO, you do not have to choose a PCP*
	NOTE: Each HCSP HMO has their own PCP change approval process				
Can family members each choose a PCP from a different IPA/ Medical Group?	*Yes—but only from network of physicians*	*Yes—but only from network physicians*	*N/A - PCP selection is not required*	*N/A - PCP selection is not required*	*Yes—each family member can make their own physician choice*
Do plans have these types of programs to speed the specialist referral process in network: Self referral? Express referral?	*Depends on the agreements with the medical group.*	*Yes—Advantage Referral Program allows PCP to refer member to any specialist in the WHA network who participates in the Advantage Referral Program*	*N/A - PCP selection is not required*	*N/A - PCP selection is not required*	*Yes – in a PPO, you don't have to go through a specialist referral process*
Is there an Out-of-Network benefit?	*No*	*No*	*Yes—Negotiated Fee Schedule*	*No*	*Yes—Negotiated Fee Schedule*
PRESCRIPTIONS					
If generic available, and doctor has not indicated "dispense as written," will member receive a generic equivalent rather than a name brand drug?	*Yes*	*Yes—or you must pay the brand copay plus the difference in cost between the brand name and generic equivalent*	*Yes—or you must pay the generic copay plus the difference in cost between the brand name & generic equivalent*	*If provider does NOT check DAW prescription, member gets Rx at Tier 3 costshare and will be responsible for the difference in cost between the price of the generic and brand. Note: only the Tier 3 cost share will apply towards DD/OOPM*	*Yes—or you must pay the generic copay plus the difference in cost between the brand name & generic equivalent*
If doctor writes "dispense as written" on prescription, is brand name available at the brand copay?	*Yes*	*Yes*	*No—member will have to pay the generic copay plus the difference in cost between generic and brand*	*If provider checks DAW prescription, members get Rx at the tiered copay the brand and generic cost*	*No—member will have to pay the generic copay plus the difference in cost between generic and brand*
Does health plan use Rx formulary?	*Yes*	*Yes*	*Yes*	*Yes. We use Caremark's formulary to define what is covered under plans. Please see hioscar.com/search for covered Rx drugs*	*Yes*
If medically necessary, are non-formulary drugs covered?	*Yes*	*Yes† — non-formulary copay applies* *†Prior authorization may be required for certain medications*	*Yes - see page 112*	*We only cover non-formulary drugs if they are determined to be medically necessary for a particular member. Members can have their provider apply for a Non-Formulary Exception to Caremark to prove medical necessity*	*Yes - see page 113*

Prescription copay charts are located on pages 112-113

PRESCRIPTION COPAYS

	HMO				
What is copay for covered non-formulary drugs?	**Anthem Blue Cross**	**Health Net**	**Kaiser Permanente**	**Sharp Health Plan**	**Sutter Health Plus**
Platinum HMO A	*$70*	--	*$15*	*$50*	*$25*
Platinum HMO B	--	--	*$15*	*$50*	*$25*
Platinum HMO C	--	*$30*	--	*$50*	--
Platinum HMO D	--	*$30*	--	--	--
Platinum HMO E	--	*$30*	--	--	--
Platinum EPO A	--	--	--	--	--
Platinum EPO B	--	--	--	--	--
Gold HMO A	*$80*	*$60*	*$50***	*$70*	*$25***
Gold HMO B	*$80*	*$70*	*$50*	*$75*	*$80***
Gold HMO C	--	*$70*	--	--	--
Gold HMO D	--	*$70*	--	*$70*	--
Gold HMO E	--	*$70*	--	--	--
Gold HMO F	--	*$70*	--	--	--
Gold EPO A	--	--	--	--	--
Gold EPO B	--	--	--	--	--
Gold EPO C	--	--	--	--	--
Gold EPO D	--	--	--	--	--
Silver HMO A	*$110*	*50% (up to $250 per Rx)*	*$75*	*$135*	--
Silver HMO B	*$110*	--	*$75*	*$160*	*$90*
Silver HMO C	--	*60% (up to $250 per Rx)*	*$65*	*$150***	*$40**
Silver HMO D	--	--	*80% (up to $250 per Rx)**	--	--
Silver EPO A	--	--	--	--	--
Silver EPO B	--	--	--	--	--
Silver EPO C	--	--	--	--	--
Bronze HMO A	--	*60% (up to $500 per Rx)*	*60% (up to $500 per Rx)*	*$100*	*60% (up to $500 per Rx)*
Bronze HMO B	--	--	--	*60% (up to $500 per Rx)**	*100%**
Bronze HMO C	--	--	*100%**	--	--
Bronze EPO A	--	--	--	--	--
Bronze EPO B	--	--	--	--	--

Mail order	**Anthem Blue Cross**	**Health Net**	**Kaiser Permanente**	**Sharp Health Plan**	**Sutter Health Plus**
	90 day supply—	*90 day supply— double retail copay*	*100 day supply— double retail copay*	*90 day supply— double retail copay*	*90 day supply—*
Platinum HMO A	*$25/$105/$210*	--	*$10/$30/$30*	*$20/$50/$100*	*$10/$30/$50*
Platinum HMO B	--	--	*$10/$30/$30*	*$20/$50/$100*	*$10/$30/$50*
Platinum HMO C	--	*$10/$50/$75*	--	*$20/$50/$100*	--
Platinum HMO D	--	*$10/$50/$75*	--	--	--
Platinum HMO E	--	*$10/$50/$75*	--	--	--
Platinum EPO A	--	--	--	--	--
Platinum EPO B	--	--	--	--	--
Gold HMO A	*$50/$120/$240*	*$20/$100/$120*	*$30**/$100**/$100***	*$38**/$70/$140*	*$10**/$30**/$50***
Gold HMO B	*$50/$120/$240*	*$30/$100/$140*	*$30**/$100**/$100***	*$38**/$80/$150*	*$30**/$100**/$160***
Gold HMO C	--	*$30/$125/$175*	--	--	--
Gold HMO D	--	*$30/$125/$175*	--	*$38/$70/$140*	--
Gold HMO E	--	*$30/$125/$175*	--	--	--
Gold HMO F	--	*$30/$100/$140*	--	--	--
Gold EPO A	--	--	--	--	--
Gold EPO B	--	--	--	--	--
Gold EPO C	--	--	--	--	--
Gold EPO D	--	--	--	--	--
Silver HMO A	*$50/$210/$330*	*$40/50% (up to $750 per Rx)/ 50% (up to $750 per Rx)*	*$40/$150/$150*	*$40**/$210/$270*	--
Silver HMO B	*$50/$210/$330*	--	*$40/$150/$150*	*$40**/$200/$320*	*$34/$130/$180*
Silver HMO C	--	*$30**/60% (up to $750 per Rx)/60% (up to $750 per Rx)*	*$34/$130/$130*	*$40**/$200**/$300***	*$20*/$40*/$80**
Silver HMO D	--	--	*80% (up to $250 per Rx)*/ 80% (up to $250 per Rx)*/ 80% (up to $250 per Rx)**	--	--
Silver EPO A	--	--	--	--	--
Silver EPO C	--	--	--	--	--
Silver EPO B	--	--	--	--	--
Bronze HMO A	--	*$36/60% (up to $1,500 per Rx)/60% (up to $1,500 per Rx)*	*$36/60% (up to $500 per Rx)/ 60% (up to $500 per Rx)*	*$38**/$120/$200*	*60% (up to $1,000 per Rx)/ 60% (up to $1,000 per Rx)/ 60% (up to $1,000 per Rx)*
Bronze HMO B	--	--	--	*60% (up to $500 per Rx)*/ 60% (up to $500 per Rx)*/ 60% (up to $500 per Rx)**	*100%*/100%*/100%**
Bronze HMO C	--	--	*100%*/100%*/100%**	--	--
Bronze EPO A	--	--	--	--	--
Bronze EPO B	--	--	--	--	--

†Generic copay/brand name copay/non-formulary copay, the Brand Rx deductible will apply if applicable.

* *HSA Qualified High Deductible Health Plan*
** *Deductible Waived*

PRESCRIPTION COPAYS

	HMO		EPO		PPO
What is copay for covered non-formulary drugs?	**UnitedHealthcare**	**Western Health Advantage**	**Anthem Blue Cross**	**Oscar**	**Anthem Blue Cross Life and Health Insurance Company**
Platinum HMO A	*$70*	*$50*	--	--	*Participating Pharmacy: $80* *Non-Participating Pharmacy: Not covered* *If applicable, a Brand Rx deductible of $200/$400 will apply:* *Gold PPO A* *Gold PPO C* *Gold PPO E* *A Brand Rx deductible of $250/$500 will apply:* *Gold PPO B* *A Brand Rx deductible of $300/$600 will apply:* *Gold PPO D* *Participating Pharmacy: $90* *Non-Participating Pharmacy: Not covered* *A Brand Rx deductible of $350/$700 will apply:* *Silver PPO B* *Silver PPO C* *Participating Pharmacy: 65% (up to $500 per prescription)** *Non-Participating Pharmacy: Not covered* *A Brand Combined Med/Rx/Pediatric Dental deductible will apply:* *Bronze PPO A* *Bronze PPO B*
Platinum HMO B	*$70*	*$25*	--	--	
Platinum HMO C	*$70*	--	--	--	
Platinum HMO D	--	--	--	--	
Platinum HMO E	--	--	--	--	
Platinum EPO A	--	--	--	*$25*	
Platinum EPO B	--	--	--	*$25*	
Gold HMO A	*$80*	*$75*	--	--	
Gold HMO B	*$80*	*$80***	--	--	
Gold HMO C	*$80*	*$75*	--	--	
Gold HMO D	--	*$50**	--	--	
Gold HMO E	--	--	--	--	
Gold HMO F	--	--	--	--	
Gold EPO A	--	--	--	*$75*	
Gold EPO B	--	--	--	*$80***	
Gold EPO C	--	--	--	*$75***	
Gold EPO D	--	--	--	*$75***	
Silver HMO A	*$100*	*$85*	--	--	
Silver HMO B	*$100*	*$90*	--	--	
Silver HMO C	*$100*	*80% (up to $250 per30 day supply)**	--	--	
Silver HMO D	*$100*	--	--	--	
Silver EPO A	--	--	*$90*	*80% (up to $250 per Rx)**	
Silver EPO B	--	--	*70% (up to $250 per Rx)**	*$90*	
Silver EPO C	--	--	--	*$125***	
Bronze HMO A	*60% (up to $500 per Rx)*	--	--	--	
Bronze HMO B	*100%**	*60% (up to $500 per Rx)*	--	--	
Bronze HMO C	--	*100%**	--	--	
Bronze EPO A	--	--	*$100*	*100%**	
Bronze EPO B	--	--	--	*100%*	

Mail order	**UnitedHealthcare**	**Western Health Advantage**	**Anthem Blue Cross**	**Oscar**	**Anthem Blue Cross Life and Health Insurance Company**
	90 day supply—double retail copay	*90 day supply—*		*90 day supply---*	*90 day supply:* *$38/$120/$240* *Non-Participating Pharmacy: Not covered* *If applicable, a Brand Rx deductible of $200/$400 will apply:* *Gold PPO A* *Gold PPO C* *Gold PPO E* *A Brand Rx deductible of $250/$500 will apply:* *Gold PPO B* *A Brand Rx deductible of $300/$600 will apply:.* *Gold PPO D* *90 day supply:* *$50**/$150/$270* *Non-Participating Pharmacy: Not covered* *A Brand Rx deductible of $350/$700 will apply:* *Silver PPO B* *Silver PPO C* *90 day supply: 65% (up to $1,500 per prescription)*/ 65% (up to $1,500 per prescription)*/ 65% (up to $1,500 per prescription)** *Non-Participating Pharmacy: Not covered* *A Brand Combined Med/Rx/ Pediatric Dental deductible will apply:* *Bronze PPO A* *Bronze PPO B*
Platinum HMO A	*$30/$70/$140*	*$25/$75/$125*	--	--	
Platinum HMO B	*$30/$70/$140*	*$13/$38/$63*	--	--	
Platinum HMO C	*$30/$70/$140*	--	--	--	
Platinum HMO D	--	--	--	--	
Platinum HMO E	--	--	--	--	
Platinum EPO A	--	--	--	*$13/$38/$63*	
Platinum EPO B	--	--	--	*$13/$38/$63*	
Gold HMO A	*$30**/$80/$160*	*$50/$125/$188*	--	--	
Gold HMO B	*$30**/$80/$160*	*$38**/$125**/$200***	--	--	
Gold HMO C	*$30**/$80/$160*	*$25**/$125/$188*	--	--	
Gold HMO D	--	*100%*/$75*/$125**	--	--	
Gold HMO E	--	--	--	--	
Gold HMO F	--	--	--	--	
Gold EPO A	--	--	--	*$38/$125/$188*	
Gold EPO B	--	--	--	*$38**/$125**/$200***	
Gold EPO C	--	--	--	*$25**/$125**/$188***	
Gold EPO D	--	--	--	*$38**/$125**/$188***	
Silver HMO A	*$40**/$100/$200*	*$38**/$138/$213*	--	--	
Silver HMO B	*$40**/$100/$200*	*$43/$163/$225*	--	--	
Silver HMO C	*$40**/$100/$200*	*80%*(up to $625 per Rx)/ 80%*(up to $625 per Rx)/ 80%*(up to $625 per Rx)*	--	--	
Silver HMO D	*$40**/$100/$200*	--	--	--	
Silver EPO A	--	--	*$50**/$150/$270*	*80% (up to $750 per Rx)*/ 80% (up to $750 per Rx)*/ 80% (up to $750 per Rx)**	
Silver EPO B	--	--	*70% (up to $750 per Rx)*/ 70% (up to $750 per Rx)*/ 70% (up to $750 per Rx)**	*$43/$163/$225*	
Silver EPO C	--	--	--	*$68**/$138**/$313***	
Bronze HMO A	*60% (up to $1,000 per Rx)/ 60% (up to $1,000 per Rx)/ 60% (up to $1,000 per Rx)*	--	--	--	
Bronze HMO B	*100%*/100%*/100%**	*$45/60% (up to $1,250 per Rx)/ 60% (up to $1,250 per Rx)*	--	--	
Bronze HMO C	--	*100%*/100%*/100%**	--	--	
Bronze EPO A	--	--	*$50**/$180/$300*	*100%*/100%*/100%**	
Bronze EPO B	--	--	--	*100%/100%/100%*	

†Generic copay/brand name copay/non-formulary copay, the Brand Rx deductible will apply if applicable.

* *HSA Qualified High Deductible Health Plan*
** *Deductible Waived*

DIABETIC BENEFITS	HMO				
	Anthem Blue Cross	**Health Net**	**Kaiser Permanente**	**Sharp Health Plan**	**Sutter Health Plus**
Are the following items covered under the Prescription Drug Benefit, Durable Medical Equipment Benefit or Diabetes Care Benefit of the member's selected plan design?					
Insulin	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*
Needles & Syringes	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*
Chem-Strips and/ or Testing Agents	*(Blood Test Strips) Covered under the Prescription Drug Benefits*	*Prescription Drug Benefit*	*Blood test strips are covered under Durable Medical Equipment; Urine test strips are covered under Prescription Drug Benefit*	*Diabetes Care Benefit, rather than Prescription Drug Benefit*	*Prescription Drug Benefit*
Insulin Pump Supplies	*Durable Medical Equipment Benefit*	*Covered at plan copay or coinsurance. See plan specific EOC for details*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Diabetes Care Benefit, rather than Prescription Drug Benefit*	*Durable Medical Equipment Benefit*
Glucose Monitor†	*Free Glucometer Program for certain manufacturers; otherwise, covered under Durable Medical Equipment Benefit*	*Covered as Medical Supplies rather than Prescription Drug Benefit: All other monitors covered at plan copay or coinsurance. See plan specific EOC for details*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Diabetes Care Benefit, rather than Prescription Drug Benefit*	*Prescription Drug Benefit*
Insulin Pump†	*Durable Medical Equipment Benefit*	*Covered at plan copay or coinsurance. See plan specific EOC for details*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Diabetes Care Benefit, rather than Prescription Drug Benefit*	*Durable Medical Equipment Benefit*
†Vendors for Diabetes Equipment:	*Please see carrier website for list of providers*	*Benefits are typically covered under the pharmacy benefit with participating pharmacies. Health Net will only cover certain machines.*	*Pending*	*ADS (Advanced Diabetes Supply) 390 Oak Avenue, Suite N Carlsbad, CA 92008 800-730-9887*	*Participating pharmacies and Durable Medical providers, as applicable*
SELF-INJECTABLE DRUG BENEFITS					
Are self-injectable drugs (other than insulin) covered under the Prescription Drug benefit or Medical Benefit?	*May depend on the medication. Call Pharmacy Services at 800-700-2533 to confirm*	*Medical Benefit*	*Prescription Drug Benefit*	*May depend on medication*	*Generally the Prescription Drug Benefit - However there is an exception process to cover under the Medical benefit if appropriate.*
Is pre-authorization required?	*Some medications and/or dosages may require prior authorization*	*Yes*	*Must be prescribed by a plan physician*	*Some medications and/or dosages may require prior authorization*	*The Prior-Authorization requirement is drug specific depending on many factors with safety as a primary factor.*
Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order RX vendor?	*Certain drugs must go through mail-order provider. Call Pharmacy Services at 800-700-2533 to confirm*	*No—use doctor's contracted vendor*	*Must use plan pharmacies (including affiliated pharmacies)*	*No—mail order not required*	*No*

DIABETIC BENEFITS	HMO		EPO		PPO
	UnitedHealthcare	Western Health Advantage	Anthem Blue Cross	Oscar	Anthem Blue Cross Life and Health Insurance Company
Are the following items covered under the Prescription Drug Benefit, Durable Medical Equipment Benefit or Diabetes Care Benefit of the member's selected plan design?					
Insulin	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*If available in formulary: Prescription Drug Benefit*	*Prescription Drug Benefit*
Needles & Syringes	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*If available in formulary: Prescription Drug Benefit*	*Prescription Drug Benefit*
Chem-Strips and/ or Testing Agents	*Prescription Drug Benefit*	*Prescription Drug Benefit*	*(Blood Test Strips) Covered under the Prescription Drug Benefits*	*If available in formulary: Prescription Drug Benefit*	*(Blood Test Strips) Covered under the Prescription Drug Benefits*
Insulin Pump Supplies	*Durable Medical Equipment Benefit*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Durable Medical Equipment Benefit*	*Please contact Customer Service at 877-833-5734*	*Durable Medical Equipment Benefit*
Glucose Monitor†	*Durable Medical Equipment Benefit*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Free Glucometer Program for certain manufacturers; otherwise, covered under Durable Medical Equipment Benefit*	*If available in formulary: Prescription Drug Benefit*	*Free Glucometer Program for certain manufacturers; otherwise, covered under Durable Medical Equipment Benefit*
Insulin Pump†	*Durable Medical Equipment Benefit*	*Durable Medical Equipment Benefit, rather than Prescription Drug Benefit*	*Durable Medical Equipment Benefit*	*If available in formulary: Prescription Drug Benefit*	*Durable Medical Equipment Benefit*
†Vendors for Diabetes Equipment:	*Please see carrier website for list of providers*	*Contract is with Medical Group. See PCP*	*Please see carrier website for list of providers*	*If available in formulary: Prescription Drug Benefit*	*Please see carrier website for list of providers*
SELF-INJECTABLE DRUG BENEFITS					
Are self-injectable drugs (other than insulin) covered under the Prescription Drug benefit or Medical Benefit?	*Medical Benefit*	*Medical Benefit*	*May depend on the medication. Call Pharmacy Services at 800-700-2533 to confirm*	*Self-injectable drugs are covered under prescription drug benefit. Drugs that require administration in a healthcare setting are covered under the medical benefit.*	*May depend on the medication. Call Pharmacy Services at 800-700-2533 to confirm*
Is pre-authorization required?	*Some medications and/or dosages may require prior authorization*	*Yes*	*Some medications and/ or dosages may require prior authorization. Call Pharmacy Services at 800-700-2533 to confirm*	*Yes*	*Some medications and/or dosages may require prior authorization. Call Pharmacy Services at 800-700-2533 to confirm*
Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order RX vendor?	*Yes—depends on medical group*	*Depends on medical group*	*Certain drugs must go through mail-order provider. Call Pharmacy Services at 800-700-2533 to confirm*	*No. If Tier 4, must be filled through a specialty pharmacy*	*Certain drugs must go through mail-order provider. Call Pharmacy Services at 800-700-2533 to confirm*

PEDIATRIC COVERAGE	HMO		
	Anthem Blue Cross	Health Net	Kaiser Permanente
Do you send out a separate Pediatric Dental and Vision card to employee household (for those that have dependent coverage 18 and under?)	*No*	*A pediatric dental ID card is sent to the subscriber's home address; however, Health Net does not issue a pediatric vision ID card. Members may access pediatric vision services by presenting their Health Net ID card.*	*Dental: Delta provides the following for the bundled pediatric dental policy attached to the medical policy. The primary enrollee (subscriber) is listed on the card. The enrollee info with assigned dentist is under coverage details. The reason why primary enrollee is listed is because dental appts and Delta customer service uses the primary MRN to get the Delta ID number (Region code + variable 0's+ MRN=12 digits) . The subscriber information is key information. Once the subscriber is found, the information for the dependents fall under the subscriber for the records to be pulled.* *Vision: Medical Card.*
Is the ID card under the Dependents name?	*N/A*	*No*	*Dental: See above.* *Vision: Yes.*
If the employee has dependent children 18 and under and also enrolls in the group dental program, which plan is primary?	*Assuming that the EE and dependent are the same on both policies, the policy that was effective first is the primary dental policy. If they are both effective on the same date, the pediatric dental plan would be the primary policy.*	*The pediatric dental PPO plan will be primary (please note, there is no coordination of benefits for pediatric DHMO or buy up DHMO plans).*	*Dental: The current rules that pertain to the determination of the order of benefits (most states follow the NAIC Model Rule for COB) would apply. For example:* *First – look to the birthday rule for the primary enrollee under the plans – The PE who has the earlier birthday in the year is primary and the other is secondary.* *Second – if the first rule doesn't resolve it, e.g. they are the same PE or the two PEs have the same birthday – then look to the older plan, i.e. the one that provided coverage for the child first;* *Third – if neither First or Second determine the order – if one plan is a medical plan and the other a dental plan – then the medical plan is primary and the dental plan secondary;* *Vision: N/A*
Is there coordination of benefits between the group dental plan and the Medical Pediatric Dental and Vision program?	*Yes*	*There is coordination of benefits between the group dental DPPO plan and the medical pediatric DPPO benefits. Coordination of benefits are not available for DHMO plans or vision plans.*	*Dental: See above.* *Vision: The vision benefits are built into the medical plan.*

PEDIATRIC COVERAGE	HMO			
	Sharp Health Plan	**Sutter Health Plus**	**UnitedHealthcare**	**Western Health Advantage**
Do you send out a separate Pediatric Dental and Vision card to employee household (for those that have dependent coverage 18 and under?)	*No, they should use their medical ID card Pediatric members will get their own ID card from Access Dental in addition to getting an SHP ID card. This is Access Dental's usual practice.*	*No, they should use their Medical ID card.*	*Dental Response – Yes, a separate Pediatric Dental ID card is sent at the time eligibility is processed.* *Vision ID cards are not mailed. Members can visit myuhcvision.com (directly or via the link on myuhc.com) to print an ID card on demand. ID cards are not required for service.*	*Dental: Yes, Delta Dental does provide an ID card to the EHB member.* *Vision: Medical Eye Services (MES) does not send vision ID cards. The member can go to the MES website to print a card.*
Is the ID card under the Dependents name?	*N/A, the pediatric dental ID card has the Dependent's name only; if more than 1 child in the family, each member will receive their own card from Access Dental.*	*Yes*	*Dental Response – No, the ID card is provided under the subscriber name and it is one card that applies to all dependents under the subscriber.* *Vision, from portal: Info is based on member/plan you are viewing. If viewing the dependent, the dependents name and ID are on the card.*	*Dental: Yes, each ID Card is specific to the member, indicating their own unique ID and Provider election/assignment. If one has not been elected the carrier will provide a letter explaining how to do so.* *Vision: No, the ID cards have the employee's information.*
If the employee has dependent children 18 and under and also enrolls in the group dental program, which plan is primary?	*Pediatric Dental EHB Pediatric Dental is primary. If the group also has a dental plan, some services might be billed under that plan.*	*Pediatric Dental is primary.*	*Medical Pediatric Dental plan and a UHC standalone plan, then the UHC Medical Pediatric Dental plan is primary and the UHC standalone plan would be secondary.* *For Vision, we do not COB.*	*Dental: The EHB plan is DHMO, therefore to receive benefits, a member must see their PCD. Should the member have duplicate pediatric coverage (under 19 years), then the plan is secondary (pg. 15 of the EOC).* *Vision: The child is primary and the parent's coverage is secondary.*
Is there coordination of benefits between the group dental plan and the Medical Pediatric Dental and Vision program?	*Yes, pediatric dental is primary.*	*Yes, pediatric dental is primary*	*Dental Response – If the member has a UHC Medical Pediatric Dental plan and a UHC standalone plan, then yes, we offer coordination of benefits and claims are internally processed under both plans, if the member has one plan with UHC and the other with another carrier, then, no coordination of benefits. Member would need to submit claim to one and then the other.* *There is no COB between medical plans and vision plans. Claims may be submitted to either plan.*	*Dental: Based on above, there would be no coordination of benefits. Due to the nature of a DHMO product, and this product being secondary, there is no situation where this would be applicable.* *Vision: Yes.*

HOUSE CALLS, TELEMEDICINE & OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	HMO			
	Anthem Blue Cross	**Health Net**	**Kaiser Permanente**	**Oscar**
Doctor House Calls available through Heal™ or another provider of this type of service?	*HMO plans:* *No* *EPO plans:* *Yes* *PPO plans:* *Yes*	*HMO plans:* *Yes*	*HMO plans:* *N/A*	*EPO plans:* *No*
For more Information:	*844.644.4325 (HEAL) or heal.com*	*Visit www.heal.com/healthnet or call (844) 644-4325*		
Nurse's Hotline available?	*HMO plans:* *Yes* *EPO plans:* *Yes* *PPO plans:* *Yes*	*HMO plans:* *Yes*	*HMO plans:* *Yes*	*EPO plans:* *No*
For more Information:	*Login at anthem.com/ca*	*24-Hour Nurse Advice Line 1-800-893-5597 or TTY: 711 (Found on the back of their ID cards)*	*24/7 Care Online via KP Member Services @ 800-464-4000*	
Facetime/Skype Access to Doctor?	*HMO plans:* *EPO plans:* *PPO plans:*	*HMO plans:* *Yes*	*HMO plans:* *Yes*	*EPO plans:* *No*
For more Information:	*Available through LiveHealth Online www.livehealthonline.com*	*Visit www.Teladoc.com/hn or call 1-800-Teladoc (835-2362)*	*Video appointments via the KP My Doctor Online site: https://mydoctor.kaiserpermanente.org/ncal/videovisit/#/*	
Email Access to Doctor?	*HMO plans:* *No* *EPO plans:* *No* *PPO plans:* *No*	*HMO plans:* *N/A* *This would depend on the Medical group or provider's office.*	*HMO plans:* *Yes*	*EPO plans:* *No*
For more Information:			*Via Kp.org*	
Any other alternative health care delivery service you offer?	*HMO plans:* *Yes* *EPO plans:* *Yes* *PPO plans:* *Yes*	*HMO plans:* *Yes*	*HMO plans:* *Yes*	*EPO plans:* *On demand phone calls with a doctor* *Asynchronous messaging with a doctor*
For more Information:	*Members can visit with a doctor or therapist for urgent care and behavioral health support through LiveHealth Online via phone, webcam, computer www.livehealthonline.com*	*Pursuing better health is our best defense against chronic medical conditions. That's why we created Decision Power®: Health & Wellness. With personalized tools and achievable goals, you can feel confident in your ability to make positive and lasting behavioral changes. If you're a group member, log in to www.healthnet.com*	*Phone appointments*	

HOUSE CALLS, TELEMEDICINE & OTHER ALTERNATIVE HEALTH CARE DELIVERY METHODS

	HMO			
	Sharp Health Plan	**Sutter Health Plus**	**UnitedHealthcare**	**Western Health Advantage**
Doctor House Calls available through Heal™ or another provider of this type of service?	*HMO plans:* *No*	*HMO plans:* *N/A*	*HMO plans:* *No*	*HMO plans:* *No*
For more Information:				
Nurse's Hotline available?	*HMO plans:* *Yes*	*HMO plans:* *N/A*	*HMO plans:* *Yes*	*HMO plans:* *Yes*
For more Information:	*1-800-827-4277 (1-800-82-SHARP)*		*Call the phone number on the back of the ID card to talk to an experienced registered nurse 24/7*	*Optum® Call 877.793.3655 Visit mywha.org/healthsupport*
Facetime/Skype Access to Doctor?	*HMO plans:* *Yes through the medical groups, not a plan benefit*	*HMO plans:* *N/A*	*HMO plans:* *Yes*	*HMO plans:* *No*
For more Information:	*https://www.plushcare.com/profile/book/* *https://www.sharp.com/rees-stealy/video-visit.cfm*		*Virtual Visits: www.uhc.com/virtualvisits*	
Email Access to Doctor?	*HMO plans:* *Yes*	*HMO plans:* *N/A*	*HMO plans:* *No*	*HMO plans:* *No*
For more Information:				*This is available through each individual Medical Group's system for current patients. Not linked through WHA*
Any other alternative health care delivery service you offer?	*HMO plans:* *No*	*HMO plans:* *N/A*	*HMO plans:* *No*	*HMO plans:* *No*
For more Information:				

華人保健計劃 CCHP Health Plan

CONTACT INFORMATION

Member Support	*888-775-7888*
Bilingual Support	*888-775-7888*
Internet Support	*888-775-7888*
Account Service & Membership Accounting Dept.	*628-228-3220*
Benefits, Eligibility & Enrollment Dept.	*628-228-3383*
Provider Eligibility Verification	*888-775-7888*
Federal COBRA Enrollments	*628-228-3268*
Release Authorization (for HIPAA Release Authorization Forms)	*888-775-7888*
Precertification Department	*628-228-3383*
Broker of Record Changes	*628-228-3283* *brokers@cchphealthplan.com*
Pharmacy Services	*888-775-7888*
Client Management Dept. (for rates and service issues)	*628-228-3383*
Adds/Terms	*sales@cchphealthplan.com*
Billing	*888-775-7888*
Payments	*888-775-7888*
Account Services	*888-775-7888*
Broker Services/Commissions	*628-228-3283*
Administrator	*888-775-7888*
Claims	*888-775-7888*
Tax ID Number	*94-3021419*
Cal-COBRA Department	*888-775-7888*
Mailing/Payment Address	*Attn: Accounting Department* *445 Grant Ave #700* *San Francisco, CA 94108*
Customer Service	*888-775-7888*
Small Group Cancellations/ Reinstatements	*628-228-3383*
Producer Service	*628-228-3283*
Underwriting Department	*628-228-3383*
Enrollment Department	*628-228-3383*
Pre-Authorization Department	*628-228-3383*
Broker Licensing Department	*628-228-3283*

CCHP Health Plan

PROVIDER NETWORKS

HMO Networks	*CCHP HMO (Mirrored)*
PPO Networks	*CCHP PPO (Mirrored)*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month*
Premium Amount Required for 15th?	*Yes*
Applications must be dated within	*30 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*1*

FEES

Enrollment Fee Amount	*$0*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*$0*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*N/A*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*N/A*
Is there a premium adjustment for 24 hour coverage?	*N/A*

SPECIAL CONSIDERATIONS

N/A

CCHP Health Plan

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*2*	*1*
Max. # of employees	*100*	*100*

Minimum Employer Contribution

	Group Size
	2+
Employees	*50% of lowest cost plan*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory			
	Group Size		
	1-5	*6-20*	*21+*
Employees	*100% of eligible must enroll*	*50% of eligible must enroll*	*30% of eligible must enroll*
Dependents	*N/A*	*N/A*	*N/A*
Non-Contributory			
Employees	*N/A*	*N/A*	*N/A*
Dependents	*N/A*	*N/A*	*N/A*

CCHP Health Plan

COVERAGE RESTRICTIONS

Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes - medical emergency only*
Is coverage available for out-of-state employees?	*N/A*
Max. percentage of employees residing out-of-state allowed	*N/A*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			■
Durable Medical Equipment Benefit				■	■	

†Vendors for Diabetes Equipment:
Sincere Care Medical Supply
CHME
Apria Healthcare
Byram Healthcare

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Prescription benefit for most self injectables*	*Yes*	*No - Retail/Mail - Chinese Hospital Pharmacy Mail - Costco Pharmacy*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

E.D.I.S.

EMPLOYER DRIVEN INSURANCE SERVICES

CONTACT INFORMATION

Member Support	*Phone: 888-886-7973* *Email: service@employerdriven.com* *Fax: 559-733-2325*
Bilingual Support	*Phone: 888-886-7973* *Email: service@employerdriven.com*
Internet Support	*Phone: 888-886-7973* *Email: service@employerdriven.com* *Web: www.employerdriven.com*
Provider Eligibility Verification	*Phone: 888-886-7973* *Email: service@employerdriven.com* *Fax: 559-733-2325*
Broker Support	*Phone: 888-886-7973* *Email: service@employerdriven.com*
Commissions	*Phone: 888-886-7973* *Email: accountservices@employerdriven.com*
Adds/Terms	*Email: administration@employerdriven.com* *Web Portal: www.yourbenportal.com*
Billing	*Phone: 888-886-7973* *Email: accountservices@employerdriven.com*
Claims Reimbursement	*P.O. Box 7809* *Visalia, CA 93290*
Wellness Discounts	*888-886-7973* *Email: service@employerdriven.com*
Tax ID Number	*81-4658349*

E.D.I.S.
EMPLOYER DRIVEN INSURANCE SERVICES

PROVIDER NETWORKS

HMO Networks	*N/A*
PPO Networks	*MEC, MEC Value, MEC+, MVP, Full RBP, Hybrid, Full PPO*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month*
Premium Amount Required for 15th?	*1 1/2 months premium*
Applications must be dated within	*The employee's signature date cannot be more than 60 days prior to the requested effective date for new group submissions*
Spouse/Domestic Partner Employees - 1 application or 2?	

FEES

Enrollment Fee Amount	*$500*
Type of Enrollment Fee	*One-time setup fee*
Monthly Administration Fee	*All fees are a part of the premium*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

E.D.I.S.
EMPLOYER DRIVEN INSURANCE SERVICES

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*26*	*26*
Max. # of employees	*No max.*	*No max.*

Minimum Employer Contribution

	Group Size
	2-50
Employees	*75% for 50 or fewer lives enrolled and 60% for 51 or more lives enrolled*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	2-50
Employees	*75% but not less than 50%*
Dependents	*N/A*
Non-Contributory	
Employees	*100%*
Dependents	*N/A*

E.D.I.S.
EMPLOYER DRIVEN INSURANCE SERVICES

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes—if more than 51% of their income is derived from that employer*
Are 1099 employees allowed?	*Yes—if more than 51% of their income is derived from that employer*
Are employees covered if traveling out of USA?	*Yes—for true emergencies only*
Is coverage available for out-of-state employees?	*Yes*
Max. percentage of employees residing out-of-state allowed	*The majority 51% of all eligible employees must be employees in the state of California*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■ *(If relating to diabetes)*			
Diabetic Supply Benefit				■	■	■

†Vendors for Diabetes Equipment: For Insulin Pumps please see DocFind. Glucose Monitors can be obtained at any retail pharmacy

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*N/A*	*N/A*	*N/A*
PPO plans	*Yes*	*Yes*	*Yes*

Check Rx formulary at employerdriven.com

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

Health Net®

CONTACT INFORMATION

Member Support	*800-361-3366*
Bilingual Support	*800-331-1777*
Internet Support	*www.healthnet.com*
Account Service & Membership Accounting Dept.	*800-447-8812*
Benefits, Eligibility & Enrollment Dept.	*800-224-8808 Option 3 (Mon.-Fri. 8:00 a.m.-4:30 p.m. PST)*
Provider Eligibility Verification	*800-641-7761*
Federal COBRA Enrollments	*Fax 916-935-4420 (ATTN: COBRA)*
Release Authorization (for HIPAA Release Authorization Forms)	*Fax 916-935-4420*
Precertification Department	*800-977-7282*
Broker of Record Changes/Group Termination Requests	*Fax – 800-303-3110 E-mail – ISG_AM_NORTH@healthnet.com*
Pharmacy Services	*800-600-0180*
Client Management Dept. (for rates and service issues)	*800-447-8812 (Option 2)*
Adds/Terms	*Fax 916-935-4420 Email: enrollmentunit_north@healthnet.com*
Billing	*Health Net File #52617 Los Angeles, CA 90074-2617 800-224-8808, Option 3*
Payments	*Health Net File #52617 Los Angeles, CA 90074-2617*
Account Services	*800-547-2967 (8 a.m.-5 p.m.) or via email: HN_Account_Services@Healthnet.com*
Pre-Authorization Department	*800-977-7282*
Broker Services/Commissions	*800-448-4411, Option 4*
Administrator	*Health Net Corp. Office 21281 Burbank Blvd. Woodland Hills, CA 91367*
Claims	*Health Net, LLC Commercial Claims P.O. Box 9040 Farmington, MO 63640-9040*
Tax ID Number	*Health Net of California, LLC 95-4402957 Health Net, Inc. 95-4288333*

Health Net®

PROVIDER NETWORKS

HMO Networks	*Full Network HMO, WholeCare HMO, SmartCare HMO, Salud HMO y Más, CommunityCare HMO, PureCare HSP*
PPO Networks	*Full Network PPO, Enhanced Care PPO*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month—15th OK if prior group coverage ends on 15th*
Premium Amount Required for 15th?	*1 1/2 months premium*
Applications must be dated within	*60 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*If both domestic partners and spouses are eligible as employees they can opt to enroll on one application together or separately with Health Net*

FEES

Enrollment Fee Amount	*None*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*None*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No—all employees must have Workers' Comp except those not legally required to be covered. Workers' Comp that is "pending" at the time of sale is not acceptable*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

N/A

Health Net®

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1*
Max. # of employees	*100†*	*100†*

**Must be a permanent W-2 employee that is not the owner or spouse of the owner.*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*$100 or 50% of lowest cost plan EE rate (excluding Salud)*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	1-5	*6-100*
Employees	◆◆*66%*	*50%*
Dependents	*N/A*	*N/A*
Non-Contributory		
Employees	◆◆*66%*	*50%*
Dependents	*N/A*	*N/A*

◆◆ *Those covered by another employer group plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be an employer group plan or MediCal/Medicare*

Health Net®

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes—if employed on a full-time basis for a minimum of 3 months and meeting the hour per week requirement & probationary period indicated on the Group Service Agreement. Eligible employees can be defined as employees working an average of 20 or 30 hours per week. DE-9C earnings must be reported & employee must have workers' comp. If employee is new and does not appear on last quarter's DE-9C, submit payroll records. 2 weeks of payroll are required for new hires not on the DE-9C.*
Are 1099 employees allowed?	*1099's are not eligible for coverage.*
Are employees covered if traveling out of USA?	*Emergency coverage only*
Is coverage available for out-of-state employees?	*Yes—groups of 1-100 eligible employees with over 50% of the total group located in CA are subject to the out-of-area requirements outlined below. Coverage not available in Hawaii*
Max. percentage of employees residing out-of-state allowed	*Up to 49% of total eligible population may be written on an out-of-state PPO plan. Coverage not available in Hawaii.*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Durable Medical Equipment Benefit				■	■	■

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Pharmacy Benefit*	*Yes*	*No—Specialty pharmacies are used.*
PPO plans	*Pharmacy Benefit*	*Yes*	*Pre-cert. applies, carrier-contracted vendor is optional*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

Salud con Health Net plan design varies depending on whether the Los Angeles, Orange, San Diego, and Ventura County provider network or the Mexico provider network is utilized by the employee and dependents. Therefore, the benefit information cannot be outlined on this page. Please call your Word & Brown sales representative for details.

Salud Mexico's plan design cannot be clearly outlined on this page. Please call your Word & Brown sales representative for details.

Health Net®

KAISER PERMANENTE®

CONTACT INFORMATION

Member Support	*800-464-4000*
Spanish Member Support	*800-788-0616*
Internet Support	*www.kp.org*
Provider Eligibility Verification	*800-464-4000*
Member Claims	*800-390-3510*
Release Authorization (for HIPAA Release Authorization Forms)	*Fax 858-614-3345*
Customer Connection Team	*800-790-4661, Option 2*
Commissions	*800-440-2323*
Adds/Terms	*No. Cal. Fax 858-614-3344* *So. Cal. Fax 858-614-3345* *Email: CSC-SD-SBA@KP.ORG*
Billing	*800-790-4661*
Payments	*Kaiser Foundation Health Plan* *File #5915* *Los Angeles, CA 90074* *800-731-4661*
Administrator	*Kaiser Permanente* *Health Plan* *393 E. Walnut St.* *LSRS-4* *Pasadena, CA 91103*
Emergency Claims Addresses	*Southern California* *Kaiser Foundation Health Plan, Inc.* *Claims Department* *P.O. Box 7004* *Downey, CA 90242-7004* *Northern California* *Kaiser Foundation Health Plan, Inc.* *Claims Department* *P.O. Box 12923* *Oakland, CA 94604-2923*
Tax ID Number	*94-1340523*

Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.

KAISER PERMANENTE®

PROVIDER NETWORKS

HMO Networks	*Kaiser Permanente*
PPO Networks	*PHCS/MultiPlan*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of each month*
Premium Amount Required for 15th?	*N/A*
Applications must be dated within	*30 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*2 separate applications*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS *(IF APPLICABLE)*

In California, a minimum of 1 must enroll. At least 70% of group's eligible employee population should be covered by either a group health plan or Medicare.

Employees are eligible for coverage if they live or work within the Kaiser Permanente service area ZIP Codes.

PPO plans cannot be sold as a standalone plan. PPO must be offered with one or more copayment plans. PPO may not be sold along with Chiropractic rider with any DeltaCare HMO plans.

For PPO+2 or more copay plans standard MPO rules apply.

A group can't offer more than one PPO plan.

Kaiser Permanente must be offered to all eligible employees.

Kaiser now offers coverage to PEO subgroups.

KAISER PERMANENTE®

KAISER PERMANENTE®

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1*
Max. # of employees	*100*	*100*

**In California, a minimum of 1 must enroll. At least 70% of group's eligible employee population should be covered by either a group health plan or Medicare.*

Employees are eligible for coverage if they live or work within the Kaiser Permanente service area ZIP Codes.

PPO cannot be sold as a standalone plan. PPO must be offered with one or more copayment plans. PPO may not be sold along with Chiropractic rider with any DeltaCare HMO plans.

For PPO+ 2 or more copay plans standard MPO rules apply.

Minimum Employer Contribution

	Group Size
	1-100
Employees	*50%*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	1-100 HMO & POS	*No Limit on Group Size PPO (metal tier and grandfathered plans) or POS plan (grandfathered only)*
Employees	*◆◆ 70% on any group plan*	*At least 70% of members must be enrolled under HMO/DHMO & up to 30% of members can be enrolled in the PPO plan (including HSA and HRA designs)*
Dependents	*N/A*	*N/A*
Non-Contributory		
Employees	*◆◆ 70% on any group plan*	*At least 70% of members must be enrolled under HMO/DHMO & up to 30% of members can be enrolled in the PPO plan (combined PPO and POS members)*
Dependents	*N/A*	*N/A*

◆ *Those covered by another plan are NOT considered eligible in calculating participation*
◆◆ *In order to NOT be considered eligible, the other coverage must be a group plan (i.e. through their employer or their spouse's employer) or Medicare*

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KAISER PERMANENTE®

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COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes—must be a full time employee, have an employer/ employee relationship and have workers' comp coverage. Need to submit DE-9C for proof*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes—for emergencies only*
Is coverage available for out-of-state employees?	*Yes*
Max. percentage of employees residing out-of-state allowed	*51% of eligible employees need to reside in CA*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Durable Medical Equipment Benefit				■	■	■

†Vendors for Diabetes Equipment: See kp.org for vendors

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Prescription Drug Benefit*	*No—must be prescribed by a plan physician*	*Must use plan pharmacies (including affiliated pharmacies)*
PPO plans	*Prescription Drug Benefit*	*No*	*No—levels of coverage may differ*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

Please note Kaiser Permanente summary information is contained herein but Kaiser Permanente has not reviewed the information contained within this guide and Word & Brown therefore cannot guarantee its accuracy. Please contact your Word & Brown sales representative in the event of any discrepancies. The information provided in this guide is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the "Evidence of Coverage" or "Certificate of Insurance." The KFHP Evidence of Coverage and the KPIC Certificate of Insurance contain a complete explanation of benefits, exclusions, and limitations.

KAISER PERMANENTE®

MediExcel HEALTH PLAN

CONTACT INFORMATION

Member Support	*619-365-4346;* *info@mediexcel.com*
Spanish Member Support	*619-365-4346;* *info@mediexcel.com*
Internet Support	*619-421-1659*
Provider Eligibility Verification	*619-365-4346;* *info@mediexcel.com*
Claims	*619-421-1659*
Release Authorization **(for HIPAA Release Authorization Forms)**	*619-421-1659*
Customer Service	*619-365-4346*
Commissions	*619-421-1659*
Adds/Terms	*619-421-1659* *applications@mediexcel.com*
Administrator	*619-421-1659*
Billing/Payments	*619-421-1659*
Eligibility	*619-421-1659*
Broker of Record Changes	*619-421-1659* *sales@mediexcel.com*
Cal-Cobra Department/ **Federal COBRA Enrollments**	*619-421-1659*
Small Group Cancellations/ **Reinstatements**	*619-421-1659*
Producer Service & Broker Service	*619-421-1659*
Underwriting Department	*619-421-1659*
Broker Licensing Department/ **Broker Licensing Paperwork**	*619-421-1659* *ggarcia@mediexcel.com*
Client Management Dept. **(for rates and service issues)**	*619-421-1659*
Account Services	*619-421-1659*
Benefits	*619-421-1659*
Pharmacy Services	*619-365-4346*
Wellness Discounts	*619-365-4346*
Mailing Address **(for correspondence or payments)**	*MediExcel Health Plan* *750 Medical Center Court, Suite 2* *Chula Vista, CA 91911*
Precertification Department	*619-421-1659*
Enrollment Department	*619-421-1659*
Account Service **& Membership Accounting Dept.**	*619-421-1659*
Tax ID Number	*98-0689694*

MediExcel HEALTH PLAN

PROVIDER NETWORKS

HMO Networks	*Full HMO Network*
PPO Networks	*N/A*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month*
Premium Amount Required for 15th?	*N/A - do not offer 15th of month start dates*
Applications must be dated within	*60 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*If both domestic partners and spouses are eligible as employees, they can opt to enroll together or separately.*

FEES

Enrollment Fee Amount	*0*
Type of Enrollment Fee	*0*
Monthly Administration Fee	*Based on # of enrolled employees as follows:* *1-2 EEs enroll, $15 per month;* *3 EEs enroll, $10 per month;* *4+ EEs enroll, $0 per month*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*No*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

N/A

MediExcel HEALTH PLAN

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100*	*100*

Minimum Employer Contribution

	Group Size	
	1-100 (sole carrier)	*1-100 (wrap with a CA carrier)*
Employees	*0%*	*50%*
For Dependents	*0%*	*0%*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

Contributory		
	Group Size	
	1-100 (sole carrier)	*1-100 (wrap with a CA carrier)*
Employees	*1 enrolled employee for Gold Plan; 3 or more for Platinum Plan.*	*1 enrolled employee*
Dependents	*None*	*None*
Non-Contributory		
Employees	*1 enrolled employee for Gold Plan; 3 or more for Platinum Plan*	*N/A*
Dependents	*N/A*	*N/A*

MediExcel HEALTH PLAN

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*We will continue to accept 1099's on case by case basis based on the exclusion in AB5 for the following professions:* • *barbers* • *cosmetologists* • *estheticians* • *manicurists*
Are employees covered if traveling out of USA?	*Yes - for urgency and emergency services only*
Is coverage available for out-of-state employees?	*No, unless they report to a work site location in San Diego or Imperial Valley*
Max. percentage of employees residing out-of-state allowed	*N/A*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■*	■*	■*	■*	■*	■*
Medical/Durable Medical Equipment Benefit	■	■	■	■	■	■

†Vendors for Diabetes Equipment: Plan contracts with vendors in Mexico
**Rx Drug Benefit is integrated in Benefit Plan Design*

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Prescription Drug Benefit - Rx Benefit is integrated in Benefit Plan Design*	*Yes*	*No - Via the contracted Plan Pharmacy*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

All medications are issued by Plan Pharmacy in Mexico. Benefit information shown on this page is a brief summary. Limitations and exclusions apply. Please refer to certificate book, evidence of coverage or call representative for details.

National General
Benefits Solutions

CONTACT INFORMATION

Member Support, Customer Service, Bilingual Support	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Internet Support	*NGBSSelfFunded@ngic.com*
Eligibility/Benefits	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Account Services, Client Management, Precertification Department, Enrollment Department, Bilingual Support	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Cal-COBRA, Federal COBRA Enrollments	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Release Authorization (for HIPAA Release Forms)	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Pharmacy Services, Wellness Discounts	*Allied: 888-292-0272* *Meritain: 800-925-2272*
Broker Licensing, Commissions, BOR Changes	*800-458-3246*
Billing, Payments, Administration & Claims	*Allied: 888-292-0272* *Meritain: 800-925-2272*
To contact by mail, or for payment submission	*For Allied:* *Allied Benefit Systems, Inc.* *P O Box 3205* *Carol Stream, IL 60132-3205* *For Cigna:* *Tabs* *PO Box 17031* *Winston-Salem, NC 27116-7031*

National General Benefits Solutions

PROVIDER NETWORKS

HMO Networks	*None*
PPO Networks	*Cigna, Cigna OAP, Cigna Local Plus, Aetna POS, Aetna ASA PPO, PHCS*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st or 15th*
Premium Amount Required for 15th?	*The full first month premium*
Applications must be dated within	*90 days of the effective date*
Spouse/Domestic Partner Employees - 1 application or 2?	*2*

FEES

Enrollment Fee Amount	*$0*
Type of Enrollment Fee	*None*
Monthly Administration Fee	*Varies based on TPA and commissions.*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

N/A

National General Benefits Solutions

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*2*	*2*
Max. # of employees	*200*	*No limit*

**AB1672 group of 1 with one waiver due to other group coverage*

Minimum Employer Contribution

	Group Size
	2-200
Employees	*50% regardless of waivers, or 75% after valid waivers*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	2-200
Employees*	*50%*
Dependents	*0%*
Non-Contributory	
Employees*	*50%*
Dependents	*0%*

***** *Those covered by another plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be a group plan*

National General
Benefits Solutions

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*Yes*
Are employees covered if traveling out of USA?	*For emergency coverage only*
Is coverage available for out-of-state employees?	*Yes*
Max. percentage of employees residing out-of-state allowed	*99%*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Diabetic Supply Benefit				■	■	■

†Vendors for Diabetes Equipment: Cigna

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
PPO plans	*Yes, they are covered under the Prescription Drug benefit.*	*Depends on the drug. For additional information, please use the online Cigna Drug List Tool. This tool will indicate whether a particular drug requires pre-authorization*	*Depends on the drug. For additional information, please use the online Cigna Drug List Tool. Note: The first fill can be obtained at retail. Subsequent fills are required to utilize mail order.*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

oscar

CONTACT INFORMATION

Member Support	*855-672-2788; help@hioscar.com*
Bilingual Support	*855-672-2788*
Internet Support	*855-672-2788*
Provider Eligibility Verification	*855-672-2788*
Broker Support	*brokers@hioscar.com* *855-672-2713*
Adds/Terms	*Website: https://business.hioscar.com* *brokers@hioscar.com* *855-672-2713*
Commissions	*commissions@hioscar.com*
Billing	*brokers@hioscar.com* *855-672-2788*
Claims	*Members: If you received services from an out-of-network Provider, and if that provider does not submit a claim to us, you can file the claim directly. To do so, send us a copy of your paid, itemized bill, along with a completed claim form (available on our website at http://www.hioscar.com/forms) You can send the information by mail to:* *Oscar Health Plan of California* *P.O. Box 52146* *Phoenix AZ, 85072–2146* *Alternatively, you can send the information by email to claims at submissions@hioscar.com or by fax to 888-977-2062.* *Brokers (can only discuss claims with HIPAA auth on file): 855-672-2713*
Tax ID Number	*47-3103726*

oscar

PROVIDER NETWORKS

EPO Networks	*Oscar EPO Network*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st and 15th of every month*
Premium Amount Required for 15th?	*Prorated amount for first month, after which billing cycle moves to the first of the month*
Applications must be dated within	*Applications must be received by 5 days after the effective date.*
Spouse/Domestic Partner Employees - 1 application or 2?	*Either is acceptable.*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS *(IF APPLICABLE)*

When Oscar is offered alongside another carrier, 60% of all eligible employees must enroll in a plan offered by the employer. The greater of 25% of all eligible employees, or 5 eligible employees, must enroll with Oscar.

oscar

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100*	*100*

**AB1672 group of 1 with one waiver due to other group coverage*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*Employers must contribute at least 50% of the employee premium or a minimum of $100 of the employee premium.*
For Dependents	*There is no minimum contribution requirement for dependents*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	1-100
Employees*	*60% of eligible employees after subtracting valid waivers*
Dependents	*N/A*
Non-Contributory	
Employees*	*100% of eligible employees after subtracting valid waivers*
Dependents	*N/A*

**Those covered by another plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be a group plan*

oscar

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes, if W-2 employee working 30+ hours per week.*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Yes, for emergency care. Oscar's Doctor on Call is accessible 24/7, free and unlimited.*
Is coverage available for out-of-state employees?	*No*
Max. percentage of employees residing out-of-state allowed	*49% - the CA guarantee issue definition is applicable.*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	*If available in formulary: Prescription Drug Benefit*	*If available in formulary: Prescription Drug Benefit*	*If available in formulary: Prescription Drug Benefit*	*If available in formulary: Prescription Drug Benefit*		*If available in formulary: Prescription Drug Benefit*
Diabetic Supply Benefit	*If ordered via DME vendor: Diabetic Supply Benefit*	*If ordered via DME vendor: Diabetic Supply Benefit*	*If ordered via DME vendor: Diabetic Supply Benefit*	*If ordered via DME vendor: Diabetic Supply Benefit*		*If ordered via DME vendor: Diabetic Supply Benefit*

†Vendors for Diabetes Equipment: Please contact Customer Service at (877) 833-5734.

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
EPO plans	*Self-injectable drugs are covered under the prescription drug benefit.* *Drugs that require administration in a healthcare setting are covered under the medical benefit.*	*Yes*	*No. If Tier 4, must be filled through a specialty pharmacy*
HSA Plans	*Self-injectable drugs are covered under the prescription drug benefit.* *Drugs that require administration in a healthcare setting are covered under the medical benefit.*	*Yes*	*No. If Tier 4, must be filled through a specialty pharmacy*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

oscar

SHARP HEALTH PLAN
make life better.®

CONTACT INFORMATION

Member Support/ Customer Service	*800-359-2002*
Bilingual Support	*800-359-2002, option 1*
Internet Support	*www.sharphealthplan.com*
Eligibility/Benefits	*800-359-2002*
Account Services/Client Management/ Precertification Department	*Please contact your Account Manager* *858-499-8009*
Enrollment Department	*Fax: 858-499-8399* *SHPEnrollmentGeneralMail@sharp.com*
Cal-COBRA/Federal COBRA Enrollments	*Fax: 858-499-8399* *SHPEnrollmentGeneralMail@sharp.com*
Release Authorization (for HIPAA Release Forms)	*800-359-2002*
Pharmacy Services	*800-359-2002*
Wellness Discounts	*Customer Service - 800-359-2002*
Provider Eligibility Verification	*800-359-2002*
Commissions	*858-499-8009*
Broker Licensing/BOR Changes	*858-499-8211* *Fax 858-499-8399* *ifpsales@sharp.com*
Billing	*Sharp Health Plan* *File 57248* *Los Angeles, CA 90074-7248*
Payments	*858-499-8023*
Administration	*HMO* *Sharp Health Plan* *8520 Tech Way, Ste. 200* *San Diego, CA 92123-1450* *800-359-2002*
Claims	*HMO* *Sharp Health Plan* *P.O. Box 939036* *San Diego, CA 92193*
Tax ID Number	*33-0519730*
To contact by mail, or for payment submission	*Sharp Health Plan* *8520 Tech Way, Ste. 200* *San Diego, CA 92123-1450*

SHARP HEALTH PLAN
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PROVIDER NETWORKS

HMO Networks	*Choice, Value, Performance, Premier*
PPO Networks	*Please contact your Word & Brown representative*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month*
Premium Amount Required for 15th?	*N/A - only offer first of the month effective dates*
Applications must be dated within	*30 days of effective date*
Spouse/Domestic Partner Employees - 1 application or 2?	*Use either 1 or 2*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS *(IF APPLICABLE)*

Employees must reside or work within the service area.
Guidelines for 1099 employee coverage:

- *1099 employees must appear on the prior carrier billing statement.*
- *An Employer may only add 1099 employees to their plan either at the initial enrollment or at renewal*
- *1099 employees must work full-time (minimum of 30 hours per week) on a year-round basis or 20 hours per week if the group covers part-time employees.*
- *There must be an affiliation between the employer and the employee long enough for a Federal Tax return to be filed.*
- *The employer must agree to contribute the same amount towards the premium as they would for an employee reported on a W-2.*
- *The employer must agree to offer coverage to all future 1099 employees.*
- *No more than 25% of the group may be 1099 employees.*
- *The 1099 employee verification form must be completed and submitted along with the following documentation:*
  --Letter from the employer requesting to cover 1099 employees.
  --Copies of the Form 1040 Schedule C and Form 1099 Miscellaneous for the prior year.

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PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*Minimum of 1 eligible employees**	*Minimum of 1 eligible employees**
Max. # of employees	*100*	*N/A*

**AB1672 group of 1 with one waiver due to other group coverage*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*Employer can choose between a defined amount ($100 minimum) or a percentage (50% minimum).*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	1-100
Employees	◆◆ *60% HMO Only (PPO: Please contact your Word & Brown representative)*
Dependents	*N/A*
Non-Contributory	
Employees	◆◆ *100%*
Dependents	*N/A*

◆◆ *Those covered by another plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be a group plan*

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COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Yes - if listed on employer's DE-9C*
Are 1099 employees allowed?	*Yes - 1099 Employees are not defined as an eligible employee and therefore not protected by AB1672; however, Sharp Health Plan will allow 1099 employees to enroll, subject to the guidelines listed in Special Considerations section on previous page*
Are employees covered if traveling out of USA?	*Yes - emergency services covered worldwide*
Is coverage available for out-of-state employees?	*HMO: No* *PPO: Yes*
Max. percentage of employees residing out-of-state allowed	*Not applicable*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■				
Diabetic Supply Benefit			■	■	■	■

†Vendors for Diabetes Equipment: Coordination through PMG.

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Prescription Drug Benefit* *Contact SHP for specialty medications.*	*Yes—some medications and/ or dosages may require prior authorization* *Contact SHP for specialty medications.*	*No—mail order not required, but must use contracted vendors. Vendor may differ depending on which drug is requested.* *Contact SHP for specialty medications.*
PPO Plans	*Please contact your Word & Brown sales representative.*	*Please contact your Word & Brown sales representative*	*Please contact your Word & Brown sales representative.*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

SHARP HEALTH PLAN
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SIMNSA health plan

CONTACT INFORMATION

Member Support	*800-424-4652*
Spanish Member Support	*800-424-4652*
Provider Eligibility Verification	*800-424-4652*
Claims	*Paulette Ledesama* *claims@simnsa.com* *Maggie Alonso* *claims@simnsa.com*
Release Authorization (for HIPAA Release Forms)	*enrollment@simnsa.com*
Customer Service	*800-424-4652*
Commissions	*druiz@simnsa.com*
Adds/Terms	*enrollment@simnsa.com*
Administrator	*Rfp@simnsa.com*
Billing/Payments	*bgonzalez@simnsa.com*
Eligibility	*enrollment@simnsa.com* *619-407-4082*
Broker of Record Changes	*Bmontalbo@simnsa.com*
Cal-Cobra Department/ Federal COBRA Enrollments	*enrollment@simnsa.com* *619-407-4082*
Small Group Cancellations/ Reinstatements	*enrollment@simnsa.com* *619-407-4082* *Fax 619-407-4087*
Producer Service	*ebeltran@simnsa.com* *619-407-4082, Ext. 109*
Underwriting Department	*RFP@simnsa.com*
Broker Licensing Department/ Broker Licensing Paperwork	*Bmontalbo@simnsa.com*
Tax ID Number	*N/A* *W8-BENE-E Available upon request*
Client Management Dept. (for rates and service issues)	*ebeltran@simnsa.com*
Account Services	*ebeltran@simnsa.com*
Benefits	*enrollment@simnsa.com* *619-407-4082*
Pharmacy Services	*800-424-4652*
Wellness Discounts	*Dermalife SPA & RejuviMed Clinic discounts located in the SIMNSA building*
To contact by mail, or for payment submission	*SIMNSA Health Plan* *2088 Otay Lakes Road #102* *Chula Vista, CA 91915*
Broker Services	*ebeltran@simnsa.com* *619-407-4082 ext. 109*
Precertification Department	*info@simnsa.com*
Enrollment Department	*enrollment@simnsa.com*
Pre-Authorization Department	*info@simnsa.com*
Account Service & Membership	*enrollment@simnsa.com*

SIMNSA health plan

PROVIDER NETWORKS

HMO Networks	*Members of SIMNSA Health Care have the convenience and the freedom to choose from 350 Mexican physicians conveniently located along Mexico's border with California in Mexicali, Tecate and Tijuana. Under the SIMNSA program, members are able to seek care from any participating primary care physician located throughout the three network cities, at any time.*
PPO Networks	*N/A*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*First of the month*
Premium Amount Required for 15th?	*Yes*
Applications must be dated within	*Prior to the effective date*
Spouse/Domestic Partner Employees - 1 application or 2?	*We only require 1 application*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*N/A*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*N/A*
Is there a premium adjustment for 24 hour coverage?	*N/A*

SPECIAL CONSIDERATIONS

N/A

SIMNSA health plan

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*Minimum participation of 5 subscribers are required to enroll*	*Minimum participation of 5 subscribers are required to enroll*
Max. # of employees	*Maximum participation of 100*	*Maximum participation of 100*

Minimum Employer Contribution

	Group Size
	5-100
Employees	*50%*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	5-100
Employees	*N/A*
Dependents	*N/A*
Non-Contributory	
Employees	*N/A*
Dependents	*N/A*

SIMNSA health plan

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*N/A*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*No - Only in an emergency situation*
Is coverage available for out-of-state employees?	*No*
Max. percentage of employees residing out-of-state allowed	*N/A*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			■
Medical/Durable Medical Equipment Benefit*	■	■	■			■

†Vendors for Diabetes Equipment: Contracted Vendor in Mexico

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*N/A*	*Yes*	*No*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

Sutter Health Plus
Your Health Plan

CONTACT INFORMATION

Member Support	*855-315-5800*
Spanish Member Support	*855-315-5800*
Internet Support	*N/A*
Provider Eligibility Verification	*855-315-5800*
Claims	*shpclaimsmailbox@sutterhealth.org*
Release Authorization (for HIPAA Release Forms)	*shpenrollmentmailbox@sutterhealth.org*
Customer Service	*855-315-5800*
Commissions	*shpbroker@sutterhealth.org*
Adds/Terms	*shpenrollmentmailbox@sutterhealth.org*
Administrator	*N/A*
Billing/Payments	*shpbilling@sutterhealth.org*
Eligibility	*shpenrollmentmailbox@sutterhealth.org*
Broker of Record Changes	*shpbroker@sutterhealth.org*
Cal-COBRA Department/ Federal COBRA Enrollments	*shpenrollmentmailbox@sutterhealth.org*
Small Group Cancellations/ Reinstatements	*shpbilling@sutterhealth.org*
Producer Service & Broker Service	*shpbilling@sutterhealth.org*
Underwriting Department	*N/A*
Broker Licensing Department/ Broker Licensing Paperwork	*shpbroker@sutterhealth.org*

Sutter Health Plus
Your Health Plan

PROVIDER NETWORKS

HMO Networks	*The Sutter Health Plus provider network in Northern California includes 29 hospitals and campuses, more than 8,000 providers, 21 Sutter Walk-In Care clinics, dozens of urgent care locations, and more. Visit sutterhealthplus.org/provider-search to learn more.*
PPO Networks	*N/A*
EPO Networks	*N/A*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month*
Premium Amount Required for 15th?	*N/A*
Applications must be dated within	*N/A*
Spouse/Domestic Partner Employees - 1 application or 2?	*1 application if spouse is listed as the dependent. 2 applications if they are each listed as the subscriber.*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*The employer must provide workers' compensation coverage required by law.*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*N/A. SHP does not offer 24 hour coverage plans.*
Is there a premium adjustment for 24 hour coverage?	*N/A. SHP does not offer 24 hour coverage plans.*

SPECIAL CONSIDERATIONS

Sutter Health Plus
Your Health Plan

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100*	*100*

Minimum Employer Contribution

	Group Size
Employees	*50% of the employees' monthly premiums for the lowest-cost medical plan offered by the employer.*
For Dependents	*N/A. An employer is not required to contribute to the dependent premium*
% of Total Cost	

PARTICIPATION

Contributory *Sole Carrier*	
Employees	*A minimum of 50% of all eligible employees must enroll in an SHP medical plan, less valid waivers*
Dependents	
Contributory *Slice Carrier*	
Employees	*A minimum participation is enrollment of two eligible employees in an SHP medical plan, less valid waivers*
Dependents	

Sutter Health Plus
Your Health Plan

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*Employees must receive monetary compensation from their employer, subject to Form W-2 withholdings. Commissioned employees who receive a W-2 form from their employer are eligible if they meet all other eligibility requirements.*
Are 1099 employees allowed?	*1099 or contracted employees are not eligible for coverage*
Are employees covered if traveling out of USA?	*Only urgent or emergency care is covered outside the SHP licensed service area. All members, including a dependent who lives outside the licensed service area, must receive all covered routine and follow-up care from their assigned medical group within the licensed service area.*
Is coverage available for out-of-state employees?	*Employees must live, work, or reside in SHP's licensed service area. All members, including a dependent who lives outside the licensed service area, must receive all covered routine and follow-up care from their assigned medical group within the licensed service area.*
Max. percentage of employees residing out-of-state allowed	*N/A*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Medical/Durable Medical Equipment Benefit*				■	■	■

†Vendors for Diabetes Equipment: Contract is with Medical Group. See PCP.

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Prescription Drug Benefit.*	*Depends on the drug – UM is used to drive quality, safety, and affordability*	*Depends on the drug – specialty self-injectable drugs are required to use the SHP specialty pharmacy, Accredo.*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

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CONTACT INFORMATION

Member Support	*HMO* *800-624-8822*	*PPO* *800-357-0978*
Bilingual Support	*HMO* *800-730-7270*	*PPO* *800-357-0978, Option 3*
Internet Support	*www.myuhc.com*	
Provider Eligibility Verification	*PPO* *877-842-3210*	*HMO* *800-591-9911*
Account Services	*Medical, Dental, Vision Billing and Eligibility Inquiries* *• Phone: 800-591-9911* *• Email: clientserviceoperations@uhc.com*	
Eligibility	*Medical, Dental, Vision Billing and Eligibility Inquiries* *• Phone: 800-591-9911* *• Email: clientserviceoperations@uhc.com*	
Wellness Discounts	*800-860-8773*	
Benefits	*Select Plus, Core, Select Plus HSA and HRA Medical Plans* *• Phone: 800-357-0978* *Signature, Advantage, Alliance and Focus Medical Plans* *• Phone: 800-624-8822 / Spanish: 800-730-7270*	
Federal COBRA Enrollments	*Fax: 866-372-1316*	
Release Authorization (for HIPAA Release Forms)	*Fax: 866-372-1316*	
Pharmacy Services **OptumRx®**	*Phone: 800-788-7871* *Authorization: 800-711-4555* *Online: www.optumrx.com*	
Client Management Department **(for rates and service issues)**	*Phone: 800-591-9911* *Email: clientserviceoperations@uhc.com*	
Broker Service	*800-591-9911, option 1* *clientserviceoperations@uhc.com*	
Cal-COBRA Department	*Phone: 800-318-5311*	
Broker Service/Commissions **(Small Group)**	*800-591-9911, option 1* *clientserviceoperations@uhc.com*	
Adds/Terms	*Fax: 866-372-1316* *Email: clientserviceoperations@uhc.com*	
Billing	*800-591-9911* *Online:* *Select, Select Plus, Core and Select Plus HSA Medical, Dental, Vision and Life: www.employereservices.com* *Technical Support: 1-800-651-5465* *Signature, Advantage, Alliance and Focus (Medical only):* *Email: clientserviceoperations@uhc.com*	
Payments	*800-591-9911*	
Administrator	*UnitedHealthcare* *Mail Stop CA120-0506* *Attn: Small Group Sales* *5701 Katella Ave.* *Cypress, CA 90630*	
Claims	*HMO Claims* *Claims Department* *P.O. Box 30968* *Salt Lake City, UT 84130-0968*	*PPO Claims* *P.O. Box 740800* *Atlanta, GA 30374-0800*
Tax ID Number	*PPO* *36-2739571*	*HMO* *95-2931460*

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PROVIDER NETWORKS

HMO Networks	*Signature = Full Network* *Advantage = Narrow Network* *Alliance* = High Performance Network* *Focus = Narrow Network (Lean HMO Network)* *SignatureValue Harmony = Narrow Network*
PPO Networks	*Select Plus = Full/National Network* *Core (for CA employees) = Narrow network*

**In Northern California, Alliance is only available for employers with 51 or more employees in Alameda, Contra Costa, Fresno, Kings, Madera, Marin, Merced, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, and Yolo counties.*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*1st of the month for HMO and PPO; 15th of the month for UnitedHealthcare PPO plans: Select Plus or HSA plans only (HMO cannot be offered)*
Premium Amount Required for 15th?	*Yes*
Applications must be dated within	*90 days prior to the requested effective date*
Spouse/Domestic Partner Employees - 1 application or 2?	*All groups: Participation must be satisfied. Waiving coverage due to other group coverage within the same employer is not considered a valid waiver.*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*No, if legally exempt*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*Yes, if legally exempt*
Is there a premium adjustment for 24 hour coverage?	*No*

SPECIAL CONSIDERATIONS

1) *Group must have Workers' Comp policy in force.*
2) *Employee must work or reside within UHC HMO of California's service area in order to enroll in an HMO plan.*
3) *Sole proprietors, husband/wife and owner-only groups are not eligible. Note: #4 and #5 below. Owner Only groups are permitted as long as they are not husband/wife only and must be filed as an S or C Corp.*
4) *If a child is a W2 employee that has zero ownership in the company (non-owner), they would be considered an eligible employee. In this situation they would qualify as group coverage.*
5) *Members can choose outpatient care at an In-Network independent, non-hospital affiliated provider and not pay the per occurrence deductible.*
6) *If DE-9/9C from EDD, no cover page required but may be requested by UHC UW if math does not balance. If DE-9/9C from ADP (payroll service) must submit cover page or quarterly Tax Summary to confirm total employee count.*
7) *Group must submit letter on company letterhead that contains: 1) start date of business—employer must have at least two, but not more than 100, permanent, active, full-time employees for 50% of the preceding calendar quarter, or preceding calendar year; 2) Tax ID number; 3) list of all current employees with hire date and Social Security Number for each. Must also submit a summary page, a copy of current Business License, Business Tax Certificate or receipt of payment for California Business License. If group comprised of all owner/partners with no DE-9/9C, call your representative for submission details. Husband/Wife groups or groups comprised of family members must provide separate tax or QWR documentation showing they are an owner or full-time employee. Payroll records must meet requirements listed in UnitedHealthcare Quick Reference Guide—call representative for details. Payroll must be from a payroll record service.*
8) *CORE network plans should only be quoted for CA employees. All non-CA employees must be quoted on Select Plus network plans with the exception of the following states:*
   - Alaska (AK) - Core network plans are the only option at this time for AK employees within the Choice Simplified package. AK employees cannot enroll on Select Plus plans.
   - Hawaii (HI) There is only one filed and approved HI plan that complies for HI employees (HI plan is only quoted on UeS, not externally). HI employees cannot enroll on any of the CA portfolio plans.
   - Idaho (ID) - All ID employees must enroll on the CA PPO Non-Differential plan.

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PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1**	*1**
Max. # of employees	*100*	*100*

**AB1672 group of 2 with one valid waiver due to other group coverage. UHC will allow 1 enrolling as long as they are non-related individuals with valid waivers*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*Employer Contributions – The employer must contribute a minimum of 50 percent of the employee-only premium or $100 flat contribution.*
For Dependents	*0*
% of Total Cost	*0*

PARTICIPATION

Contributory	
	Group Size
	1-100
Employees	◆◆ *A minimum of 60 percent participation is required for contributory groups, excluding COBRA participants.**
Dependents	*N/A*
Non-Contributory	
Employees	◆◆*100%†*
Dependents	*N/A*

◆◆ *Those covered by another plan are NOT considered eligible in calculating participation.*

† *Additional participation guidelines for all groups applying for coverage:*
- *Groups excluding classes may not offer another carrier alongside UnitedHealthcare.*
- *When the employer contributes 100 percent toward the employee premium, 100 percent of Eligible Employees must enroll.*
- *COBRA participants and employees in waiting period are not considered Eligible Employees and are not included when determining the participation requirement.*

* *Excluding valid waivers for spousal group coverage through another employer's plan, parental group coverage through another employer's group plan for a dependent up to age 26, spousal COBRA/state continuation, Medicare (parts A and B required), TRICARE or at-no-cost, government-sponsored plans including an Exchange. Individual waivers are considered valid waivers for non-grandfathered groups beginning January 2015.*

UnitedHealthcare®

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*UnitedHealthcare no longer considers 1099 employees as eligible for coverage. If the group has only 1 owner, UHC requires at least one W2 Common Law Employee, who is not the spouse of the owner, to qualify the group and the W-2 needs to be enrolled.* *1099 contracted employees currently on UHC Small Group will need to be transitioned to other coverage at renewal. Outside of UHC.*
Are employees covered if traveling out of USA?	*Emergency coverage only*
Is coverage available for out-of-state employees?	*HMO: No* *Select Plus: Yes—but no more than 25% of the group can be located in Vermont* *Core: No*
Max. percentage of employees residing out-of-state allowed	*The group will be rated in the state with 51% of the eligible employees. If there is not 51% of the eligible employees in any state, special guidelines apply to determine base location. Contact your Word & Brown representative. Also, for multi-state groups contact your Word & Brown representative or refer to the Underwriting Guidelines. Multisite capabilities are now guaranteed issue.*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Durable Medical Equipment Benefit				■**	■	■

***Usually Durable Medical Equipment Benefit—supplies containing insulin are covered under Prescription Drug Benefit*

†Vendors for Diabetes Equipment:
Animas Diabetes Care, LLC: Diabetic Insulin Pumps; http://www.animascorp.com
Roche Insulin Delivery Systems: Diabetic Insulin Infusion Pump and Supplies; http://www.accu-checkinsulinpumps.com
MiniMed Distribution Corp.: Diabetic Insulin Pumps; http://www.minimed.com
Smiths Medical MD, Inc.: Diabetic Insulin Infusion Pump and Supplies; http://www.cozmore.com
(For additional vendors, please contact your Word & Brown representative)

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Medical Benefit*	*Yes*	*Varies by specific self-injectable medication*
PPO Plans	*Covered under the specialty pharmacy prescription drug benefit*	*Notification may be required*	*Through UHC's specialty pharmacy program—call your Word & Brown representative*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

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Western Health Advantage

CONTACT INFORMATION

Member Support	*888-563-2250 or 916-563-2250*
Spanish Member Support	*888-563-2250 or 916-563-2250*
Internet Support	*www.westernhealth.com*
Provider Eligibility Verification	*888-563-2250 or 916-563-2250*
Claims	*888-563-2250 or 916-563-2250*
Release Authorization (for HIPAA Release Forms)	*www.westernhealth.com*
Customer Service	*888-563-2250 or 916-563-2250*
Commissions	*916-563-2206*
Adds/Terms	*916-563-2206* *eligibility@westernhealth.com*
Administrator	*Western Health Advantage* *2349 Gateway Oaks Drive, Suite 100* *Sacramento, CA 95833*
Billing/Payments	*916-563-2206* *premiumbilling@westernhealth.com*
Eligibility	*916-563-2206* *Fax: 916-568-0334* *eligibility@westernhealth.com*
Broker of Record Changes	*888-499-3198 or 916-563-3198* *Fax: 916-568-1338* *whasales@westernhealth.com*
Cal-COBRA Department/ Federal COBRA Enrollments	*916-563-2206*
Small Group Cancellations/ Reinstatements	*888-499-3198 or 916-563-3198*
Producer Service & Broker Service	*888-499-3198 or 916-563-3198*
Underwriting Department	*888-499-3198 or 916-563-3198*
Broker Licensing Department/ Broker Licensing Paperwork	*888-499-3198 or 916-563-3198*

Western Health Advantage

PROVIDER NETWORKS

HMO Networks	*Western Health Advantage*
PPO Networks	*N/A*

UNDERWRITING & ENROLLMENT REQUIREMENTS

Carrier's Effective Date	*First of the month only*
Premium Amount Required for 15th?	*N/A*
Applications must be dated within	*30 days*
Spouse/Domestic Partner Employees - 1 application or 2?	*1 application*

FEES

Enrollment Fee Amount	*N/A*
Type of Enrollment Fee	*N/A*
Monthly Administration Fee	*N/A*

24 HOUR COVERAGE

Is Workers' Comp required on corporate officers, partners and sole proprietors?	*N/A*
Is on-the-job covered for corporate officers, partners and sole proprietors?	*N/A*
Is there a premium adjustment for 24 hour coverage?	*N/A*

SPECIAL CONSIDERATIONS

N/A

Western Health Advantage

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	Initial	After Issue
Min. # of employees	*1*	*1*
Max. # of employees	*100*	*100*

Minimum Employer Contribution

	Group Size
	1-100
Employees	*50% of base plan offered by WHA*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

Contributory	
	Group Size
	1-100
Employees	*1 enrolled or 2 enrolled if dual option*
Dependents	*N/A*
Non-Contributory	
Employees	*1 enrolled or 2 enrolled if dual option*
Dependents	*N/A*

Western Health Advantage

COVERAGE RESTRICTIONS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*No*
Are employees covered if traveling out of USA?	*Must reside within service area for 8 continuous months to be eligible (except at school)*
Is coverage available for out-of-state employees?	*No*
Max. percentage of employees residing out-of-state allowed	*N/A*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
Rx Drug Benefit	■	■	■			
Medical/Durable Medical Equipment Benefit*				■	■	■

†Vendors for Diabetes Equipment: Contract is with Medical Group. See PCP.

Self-Injectable Drug Benefits

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
HMO plans	*Medical Benefit*	*Yes*	*Depends on medical group*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

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ANCILLARY CONSUMER EXCHANGE PROGRAM

ChoiceBuilder®

CONTACT INFORMATION

Customer Service Center	*ChoiceBuilder*	*866-412-9279*
Member Service - Dental	*Ameritas* *Anthem Blue Cross* *Delta Dental HMO* *Delta Dental PPO* *MetLife*	*800-487-5553* *877-567-1804* *800-422-4234* *888-335-8227* *800-942-0854*
Member Service - Vision	*EyeMed (provided by Ameritas)* *VSP*	*866-289-0614* *800-877-7195*
Member Service - Chiropractic/Acupuncture	*Landmark Healthplan*	*800-638-4557*
Member Service - Life	*Assurity Life Insurance Company*	*800-869-0355*
Broker Services & Commissions	*ChoiceBuilder*	*E-mail: commissions@choicebuilder.com* *Phone: 714-567-4390*
Broker of Record Changes	*ChoiceBuilder*	*E-mail: commissions@choicebuilder.com* *Fax: 714-908-3519* *Phone: 714-567-4390*
Adds/Terms	*ChoiceBuilder*	*Fax 866-412-9280* *memberprocessing@choicebuilder.com*
Dental Claims	*Ameritas* *P.O. Box 82520* *Lincoln, NE 68501* *Fax 402-467-7336* *Anthem Blue Cross Life and Health Insurance Company* *P.O. Box 1115* *Minneapolis, MN 55440*	*Delta Dental* *12898 Towne Center Drive* *Cerritos, CA 90703* *MetLife* *PO Box 1115* *Minneapolis, MN 55440-1115*

CALIFORNIA COVERAGE

Coverage area varies by plan. Please contact your Word & Brown representative for a quote.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*N/A*
What states are allowed (or not allowed) for out-of-state coverage?	*All states eligible*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned:	*Employer's home office must be located in CA. If incorporated in another state, documents must show a home office address in CA.*

PROVIDER NETWORKS

Ameritas	*PPO Network*
Anthem Blue Cross	*Dental Complete Network*
Delta Dental HMO	*DeltaCare USA*
Delta Dental PPO	*Delta Dental PPO Network and Delta Dental Premier Network**
EyeMed (provided by Ameritas)	*Access Network*
Landmark Healthplan	*Chiropractic*
MetLife	*PDP Plus Network*
VSP - Vision	*VSP Choice Network*

**Network availability based on plan*

DUAL OPTION (MIX & MATCH)

2 Dental Carriers / 2 Vision Carriers / Chiro-Acupuncture / Life.
Call your Word & Brown representative for more details.

ChoiceBuilder®

ChoiceBuilder®

PLAN ELIGIBILITY REQUIREMENTS

Dental Benefits

Employer Sponsored	Voluntary
Participation Requirements • *Minimum Employee participation must be at least 70%* • *Minimum Dependent participation is 0%* **Minimum Employer Contribution** • *The Employer must contribute at least 50% of the lowest cost benefit design* • *No Employer contribution is required for Dependent Coverage*	**Participation Requirements** • *Minimum of 10 eligible Employees with a minimum participation of at least 5 enrolled in dental* • *Minimum Dependent participation is 0%* **Minimum Employer Contribution** • *No Employer contribution required*

Vision Benefits

Employer Sponsored	Voluntary
Participation Requirements • *Minimum Employee participation must be at least 70%* • *Minimum Dependent participation is 0%* **Minimum Employer Contribution** • *The Employer must contribute at least 50% of the lowest cost benefit design* • *No Employer contribution is required for Dependent Coverage*	**Participation Requirements** • *No minimum participation required* **Minimum Employer Contribution** • *No Employer contribution required*

Chiropractic/Acupuncture Benefits

Employer Sponsored	Voluntary
Participation Requirements • *100% Employee participation is required* • *Minimum Dependent participation is 0%* **Minimum Employer Contribution** • *The Employer must contribute 100% of the Employee premium* • *Dependent Coverage is included as this is a discount plan only*	**Participation Requirements** • *No minimum participation required* **Minimum Employer Contribution** • *No Employer contribution required*

Life Benefits

Employer Sponsored
Participation Requirements • *100% Employee participation is required* **Minimum Employer Contribution** • *The Employer must contribute 100% of the Employee premium*

ChoiceBuilder®

RATING INFORMATION

Group Size	*2-199*
Rate Guarantee	*12 months*
Rates Vary by Industry?	*Dental- varies by carrier* *Life - Yes* *Vision & Chiro - No*

OUT-OF-NETWORK CLAIM ADJUDICATION

HMO: N/A

Ameritas
Silver Benefits – Average prevailing fee;
Gold/Platinum Benefits – 80th percentile of U&C

Anthem Blue Cross
Silver Benefits - MAC
Gold/Platinum Benefits - 90th percentile of U&C

Delta Dental PPO
Silver/Gold Benefits – Max. allowable charge.
Platinum Benefits – Premier dentists agree to accept their Premier Contracted Fee as payment in full. Non-contracted dentists are reimbursed according to the program allowance, which is the amount determined by a set percentile level of all charges for such services by providers with similar professional standing in the same geographical area.

MetLife
Silver Benefits - MAC
Platinum Benefits - 70th percentile of U&C
Platinum Plus Benefits - 90th percentile of U&C

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*No*
Any ineligible industries?	*Yes—Delta Dental PPO Employer sponsored plan—contact your Word & Brown representative.*
Virgin groups eligible?	*Yes*
Quarterly/annual wage report required?	*Upon request*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*Yes—eligible non-union members only. Employer to submit union billing*
Minimum group size	*2*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Delta Dental DHMO – N/A

Delta Dental PPO – N/A

Anthem Blue Cross – N/A

Ameritas – At initial group enrollment, employer-sponsored groups with 10+ eligible employees and prior continuous uninterrupted orthodontic coverage of 12 months will waive orthodontic waiting period.

MetLife – N/A

SPECIAL CONSIDERATIONS

Word&Brown®

DENTAL

RENEWAL INFORMATION - DENTAL

	Aetna	Ameritas	Anthem Blue Cross	BEST Life and Health Insurance Company	Blue Shield of California
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Account client managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Contact support@gotodais.com. Send the renewing group name, broker name and ZIP code. The assigned Ameritas representative will call broker to assist.*	*Broker Services: 1-800-678-4466* *Account Manager as assigned to ACE agents* *Contact Anthem Connect connect@anthem.com 877-567-1802*	*Broker Services Department 800-433-0088* *If adding a new line of coverage to group, contact assigned sales representative.*	*Producer Services 800-559-5905* *If related to up-selling Dental, Vision and Life, contact Account Manager.*
Deadline for submission of group level renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*By the end of the renewal month.*	*The completed documentation, including all necessary Anthem Blue Cross forms, must be received by Anthem Blue Cross within 30 days of the requested anniversary date. Non-anniversary benefit modifications will not be allowed.*	*Renewal changes at the group level can be made at the time of their renewal, prior to renewal effective date. For future renewal - if a group would like to have the changes made at their next renewal, we would have to process it before the invoice for that month is processed, which is more than 30 days. As for effective date, I would recommend 60-90 days before their renewal.*	*We prefer to receive changes by the 1st of the renewal month but will accept changes through the renewal month up to the last business day of the renewal month.*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*Within 30 days of qualifying event.*	*A. Covered subscribers may move to a different product offered by their group at the anniversary month.* *B. A subscriber can request a change in medical benefits by completing the Employee Change Form or the Plan Change Request form on their group's anniversary date.*	*We have O/E open a month prior to their renewal month and continues through the end of the renewal month. In that window, the employee can make changes to their coverage.*	*We prefer to receive changes by the 1st of the renewal month but will accept changes through the renewal month up to the last business day of the renewal month.*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Brokers have access to Aetna's online enrollment system - e-enroll. They can run a report to view membership after changes are processed.*	*The broker may call Ameritas Agent Services to be set up on Ameritas Broker Portal for access. Call 855-517-5307, option 4*	*Yes - through Producer Toolbox at https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc*	*Yes - through the Broker Portal at: https://www.bestlife.com/brokers First time users must register by contacting 800-433-0088.*	*Yes - group level changes are done in the renewal center (SGOR tool). Employee level changes are done on employer connection plus. www.blueshieldca.com*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Contact dedicated Account Client Managers by phone or email.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Online when group is registered*	*Email or fax*	*Online Broker Portal: https://www.bestlife.com/brokers*	*Any submission is 7-10 business days standard processing*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Brokers can go to Producer World and access renewal online OR contact Account client managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Online when group is registered, or contact support@gotodais.com. Send the renewing group name, broker name and ZIP code. The assigned Ameritas representative will call broker to assist.*	*Through Producer Toolbox at https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc* *Contact Anthem Connect connect@anthem.com 877-567-1802*	*Call Broker Services Department 800-433-0088*	*Broker can pull a PDF copy of their renewal by logging into producer connection under online renewals*
How far in advance do these receive their renewal material - Groups? Broker?	*Per CA law, brokers receive their renewals 60 days in advance of the renewal date. Brokers can view the renewals on Producer World as soon as they are mailed (usually 5-7 days in advance of mail).*	*At least 90 days*	*60 days. Brokers can also view the renewals on Producer Toolbox between 60-70 days.*	*60 days*	*Approximately 90 days*

RENEWAL INFORMATION - DENTAL

	CalCPA Health	CaliforniaChoice®	California Dental Network	ChoiceBuilder®	Delta Dental	Delta Dental/ Morgan White
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Banyan Administrators: 877-480-7923*	*Renewals at 800-542-4218*	*1-877-433-6825, ext 1408*	*866-412-9279*	*415-989-7443, ext. 220*	*888-859-3795*
Deadline for submission of group level renewal changes & their effective date?	*The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*We request changes to be submitted within 30 days. We understand that we would receive additional changes or request after the time. We will process the request with the effective date provided. If we need to process a retro adjustment we will process the adjustment. Please note any retro adjustment over 60 days will require authorization.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*Whether a new group submission or benefit change at renewal, our cut-off dates that you use for new business would apply.*	*Contact your Word & Brown representative*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*We request changes to be submitted within 30 days. We understand that we would receive additional changes or request after the time. We will process the request with the effective date provided. If we need to process a retro adjustment we will process the adjustment. Please note any retro adjustment over 60 days will require authorization.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*Whether a new group submission or benefit change at renewal, our cut-off dates that you use for new business would apply.*	*Contact your Word & Brown representative*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Contact Banyan Administrators to gain system access*	*Yes: www.calchoice.com*	*Yes, but broker would have to request access to employer portal via written letter or form. Request would have to come from employer group* *Note: not available for groups on EDI*	*Yes via Broker Portal, or call customer service 866-412-9279*	*No*	*Yes, via broker portal brokers.mwadmin.com*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Email*	*Fax or email*	*Email:* *membership@caldental.net*	*Email* *On a member level: memberprocessing@choicebuilder.com* *On a group level: groupprocessing@choicebuilder.com*	*Email* *dvalenzuela@alliedadministrators.com*	*In writing via email or fax* *groupaddsandchanges@morganwhite.com* *Fax: 601-956-3795*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Call Banyan Administrators*	*Renewals at 800-542-4218*	*Contact Account Manager via email or phone*	*Call customer service 866-412-9279*	*415-989-7443, ext. 220 or dvalenzuela@alliedadministrators.com*	*888-859-3795*
How far in advance do these receive their renewal material - Groups? Broker?	*60 days*	*60 days*	*60-90 days*	*60 days*	*Groups: 60 days* *Brokers: 90 days*	*60-90 days*

RENEWAL INFORMATION - DENTAL

	E.D.I.S.	Guardian	Health Net	Humana	Liberty Dental	Lincoln Financial Group	MediExcel Health Plan
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Renewal Department: 888-886-7973 renewal@employerdriven.com*	*Contact your Word & Brown representative, or call 800-459-9401*	*Account Management: 800-447-8812, option 2. Dental quote will show on group's renewal even if they do not have dental so they can review their options.*	*For group level quoting and negotiation you would contact your assigned retention executive. Member level questions, summaries or general group info, contact Market supports at 800-592-3005, or email sbmarketsupport@humana.com*	*Contact Account Manager, or email nationalaccounts@libertydentalplan.com*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*sales@mediexcel.com*
Deadline for submission of group level renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*Contact your Word & Brown representative*	*The group has through the end of the month they are renewing in to make any changes. The effective date of these changes would be the 1st of their open enrollment month.*	*All plan changes must be received by the 5th of the month they are to be effective in. Example 4-1 plan change, must be received by 4-5 at the latest. Membership you have 30 days to collect and submit applications from the effective date. HOWEVER, we allow online enrollment up to 60 days past the effective date. The big thing to note if pushing the boundaries on this is that the app has to be signed within the O.E. window, when processing online it asks you when the document was signed and if it's outside of the 30 day window it won't be processed.*	*LIBERTY shall provide written notice of any changes to the Benefits, Copayments and/or Premium rates at least sixty (60) days prior to the end of the then-current term. The deadline for submission of group level renewal changes is thirty (30) days prior to the end of the then-current term*	*Plan changes can be made through out the year through our amendment process. We usually deliver renewals 90 days in advance of effective date.*	*Group level changes must be submitted by the 10th day of the effective month*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*Contact your Word & Brown representative*	*For renewal changes on employee/dependent coverage for Open Enrollment need to be received by the end of the month of the group's open enrollment month. If the probationary period has been met, the changes would be effective the 1st of the month of the group's Open Enrollment month.*	*All plan changes must be received by the 5th of the month they are to be effective in. Example 4-1 plan change, must be received by 4-5 at the latest. Membership you have 30 days to collect and submit applications from the effective date. HOWEVER, we allow online enrollment up to 60 days past the effective date. The big thing to note if pushing the boundaries on this is that the app has to be signed within the O.E. window, when processing online it asks you when the document was signed and if it's outside of the 30 day window it won't be processed.*	*Changes/new enrollments should be received by the 20th of the month prior to the renewal date to ensure timely processing and delivery of the welcome packets for new enrollees.*	*Plan changes can be made throughout the year through our amendment process. We usually deliver renewals 90 days in advance of effective date.*	*10 days after effective date*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Yes: yourbenportal.com*	*Yes, through Broker Portal www.guardiananytime.com*	*Yes: https://www.healthnet.com/portal/broker/home.ndo Note: In order for a broker to have access to adds/terms, the Employer Group must first register on healthnet.com and give their broker permissions to such changes.*	*Yes via agent portal*	*No*	*No*	*No*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Email*	*Contact your assigned Guardian Sales Representative*	*Email or fax to Account Management.*	*Membership Changes made via broker or employer portal are the fastest (2+ space), fax is the slower method 866-584-9140. Group level plan changes should be sent to beclericals@humana.com Email enrollment is not available except through the broker portal secure messaging center. To check status, sbmarketsupport@humana.com or via phone 800-592-3005*	*Email nationalaccounts@libertydentalplan.com*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*applications@mediexcel.com*
How does a broker secure a copy of a missing renewal? (If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)	*Contact E.D.I.S. renewal department 888-886-7973 renewal@employerdriven.com*	*Contact your Guardian Sales Representative, or call 800-459-9401*	*Call Account Management at 800-447-8812 option 2*	*Agent portal*	*Contact Account Manager, or email nationalaccounts@libertydentalplan.com*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*sales@mediexcel.com*
How far in advance do these receive their renewal material - Groups? Broker?	*Approximately 60 days*	*75 days*	*60 days for groups, 67+ days for brokers depending on renewal month*	*Around 75 days in advance, released on the 20th of a month.*	*60 days*	*60-90 days*	*90 days*

RENEWAL INFORMATION - DENTAL

	MetLife	Nippon Life Benefits	Principal	Reliance Standard	SmileSaver/ MetLife DHMO	UnitedHealthcare	Unum
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Call Broker Services: 1-800-275-4638, option 3*	*Contact assigned Account manager 844-486-8471*	*Contact assigned Account Executive*	*Contact group administration 800-659-2223, option 2*	*Email pmontenegro@metlife.com*	*Renewal account consultant*	*Call Ask Unum team 1-800-275-8686*
Deadline for submission of group level renewal changes & their effective date?	*For plan design changes we request that those are submitted prior to the effective date.* *For effective date changes we request that those are submitted 90 days in advance of the renewal anniversary.*	*Contact your Word & Brown representative*	*Contact your Word & Brown representative*	*For our SmartChoice small group products, we do not have these deadlines. Our groups do not renew, they just continue. If a group makes a change or add/ deletes an employee, they just contact our office and we make the change in real time.*	*By the end of the renewal month*	*Group level changes must be submitted by the 5th day of the effective month.*	*Contact your Word & Brown representative*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*Adds/ Terms are continuous throughout the year and are dependent on the groups waiting periods.*	*Contact your Word & Brown representative*	*Contact your Word & Brown representative*	*For our SmartChoice small group products, we do not have these deadlines. Our groups do not renew, they just continue. If a group makes a change or add/ deletes an employee, they just contact our office and we make the change in real time.*	*Within 30 days of qualifying event*	*30th day of the renewal month.*	*Contact your Word & Brown representative*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Yes - Broker must submit application for MetLink portal metlink.com/*	*Yes via Employer Portal, but must be approved by group*	*Yes, via eService portal*	*Yes, via E-services portal reliancestandard.com/dental-vision*	*No*	*Yes: employerservices.com*	*Yes, via sales portal. Complete application for access www.unum.com/*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Fax or email to service email address assigned to group*	*Contact assigned Account manager 844-486-8471*	*Online via eService portal*	*Email adminserv@employeebenefitservice.com*	*Email pmontenegro@metlife.com*	*Contact your Renewal Account Consultant*	*Email askunum@unum.com*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Call Broker Services: 1-800-275-4638, option 3*	*Contact assigned Account manager 844-486-8471*	*Contact assigned Account Executive*	*Contact group adminstration 800-659-2223, option 2*	*Email pmontenegro@metlife.com*	*Broker should contact Renewal Account Consultant. Please see contact sheet.*	*Call Ask Unum team or email* *1-800-275-8686 askunum@unum.com*
How far in advance do these receive their renewal material - Groups? Broker?	*75 days*	*60 days*	*60 days*	*60-90 days*	*60 days*	*Approximately 60-75 days*	*60 days*

DENTAL BENEFITS COMPARISON

	Aetna	Ameritas	Anthem Blue Cross	BEST Life and Health Insurance Company	Blue Shield of California	CalCPA Health
Are there any industries that are ineligible?	*Yes - if written standalone*	*Dental Offices, all marijuana related businesses.*	*Dental Offices & SIC code 8811 (personal household)*	*Yes - Dental Offices/Clinics*	*Yes, 8811 Private Households*	*Participation is available to the CA-based owners and employees of accounting firms in public practice or offering general financial services (SIC 8721)*
Are there any industries that receive an automatic rate load?	*No*	*No*	*PPO: Yes* *Dental Net: No* *Note: SIC codes are taken into consideration for pricing purposes.*	*No*	*No*	*No*
Is over age dependent verification required?	*No*	*No*	*No*	*No*	*Yes*	*No*
Maximum age/units	*Maximum age: 26*	*Maximum age: 26* *(Follows state laws, can request special dependent age through Agent Services.)*	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*
Do you offer Open Enrollment to DMO & DPO groups at their anniversary each year?	*Groups of 2-9: Enrollment is possible for any employee to elect dental plan coverage during the first 31 days of initial eligibility* *Groups of 10-50: Yes*	*Yes* *DMO: N/A*	*Yes, we offer Open Enrollment for DHMO and PPO/DPP products.*	*Yes*	*DHMO: Yes* *DPPO: Yes*	*Yes*
At Open Enrollment, do members have any restrictions (such as reduced benefits or a waiting period)?	*Groups of 2-9: An employee or dependent who does not enroll within 31 days of first becoming eligible (or after a qualifying life event) is subject to the Late Entrant Provision. They would have a 12-month waiting period for Basic & Major services; and 24-month waiting period for Orthodontia* *Groups of 10-50: There is no BWP for members who enroll during the OE period*	*Yes* *Waiting periods vary by plan: Type 3 0-12 month; Ortho 0-12 month*	*No*	*No restrictions - it is a true open enrollment*	*No restrictions— it is a true open enrollment* **12 month waiting period applies to all Voluntary DPPO plans*	*No*
Is there a waiting period for major services for new hires (including Enrollees who initially waived the waiting period)?	*Groups of 2-9: Waiving of the waiting period is done at the group level. Employers with prior dental coverage, and their new hires, will not be required to meet a waiting period prior to services being rendered* *Groups of 10-50: Please contact your W&B representative*	*If Employee does not enroll at initial eligibility date, he/she may enroll as a late entrant (Late Entrant Provision will apply) or wait and enroll at the next open enrollment time (renewal). Waiting periods vary by plan: Type 3: 0-12 month; Ortho: 0-12 month*	*No benefit waiting periods for Employer Sponsored plans.* *Yes for Voluntary plans.*	*Yes - Restrictions apply based on enrollment size, participation and contribution*	*Yes for all DPPO Voluntary plans this is a 12 month waiting period for major services. It can be waived if the group had prior BSC coverage, with no lapse preceding the requested effective date.*	*No*
Are employees who reside outside of California eligible?	*Yes*	*Yes*	*PPO: Yes DHMO: No*	*Yes*	*Yes, for PPO dental products only*	*Yes*
Any state restrictions?	*Call your Word & Brown representative*	*Groups situs in CA and NV*	*No state restrictions*	*No state restrictions*	*No state restrictions on DPPO plans No more than 49% of employees may reside outside of California.*	*No state restrictions*

DENTAL BENEFITS COMPARISON

	CaliforniaChoice®	California Dental Network	ChoiceBuilder®	Delta Dental	Delta Dental/ Morgan White	E.D.I.S.
Are there any industries that are ineligible?	*No*	*No*	*Yes - contact your Word & Brown representative.*	*See page 203*	*No*	*Yes-SIC's: 8021 & 8111*
Are there any industries that receive an automatic rate load?	*No*	*No*	*Yes*	*PPO: Yes* *DeltaCare USA: No*	*No*	*No*
Is over age dependent verification required?	*No*	*No*	*No*	*No*	*Yes*	*No*
Maximum age/units	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*	*Maximum age: 26*
Do you offer Open Enrollment to DMO & DPO groups at their anniversary each year?	*Yes*	*DHMO: Yes*	*Yes*	*PPO: Yes* *DeltaCare USA: Yes* *Dual Choice: Yes*	*N/A*	*Yes*
At Open Enrollment, do members have any restrictions (such as reduced benefits or a waiting period)?	*Yes - same as new hire*	*DHMO: No*	*Call your Word & Brown representative*	*PPO: No* *Voluntary PPO: Yes - for switching between plans. Late enrollees/dependents may enroll under DeltaCare USA and switch to a PPO after one year.* *DeltaCare USA & Dual Choice: No*	*N/A*	*No*
Is there a waiting period for major services for new hires (including Enrollees who initially waived the waiting period)?	*DHMO: No* *PPO: Yes*	*No*	*If Employee does not enroll at initial eligibility date, he/she may not enroll until next group anniversary date (Renewal) and basic services will require a 3-6 month waiting period and major / ortho services will require a 12 to 24 month waiting period.*	*PPO: No* *DeltaCare USA: No* *Voluntary PPO: Yes*	*N/A*	*No waiting period for Employer Paid. 12 month wait for major benefits or late enrollees and add-ons with no prior dental plan for Voluntary. No waiting period for individuals with prior dental*
Are employees who reside outside of California eligible? **Any state restrictions?**	*DHMO: No* *PPO: Yes*	*No - DHMO members must reside in CDN service area*	*DMO: No* *DPO: No state restrictions*	*PPO: Yes* *DeltaCare USA: No*	*Yes* *States allowed: AL, DE, DC, FL, GA, LA, MS, MT, NV, NY, PA, TX, UT & WV*	*Yes* *Call your Word & Brown representative to determine any state restrictions*

DENTAL BENEFITS COMPARISON

	Guardian	Health Net	Humana	Liberty Dental	Lincoln Financial Group	MediExcel Health Plan	MetLife
Are there any industries that are ineligible?	*No, however some industries may require underwriter review.*	*No*	*Dental offices*	*Private Households*	*Yes, Dental Offices, & Private Households*	*No*	*Yes - Excluded SIC's: 8021, 8072, 8200-8299, 8811, 9999*
Are there any industries that receive an automatic rate load?	*Rates are developed based on SIC codes, as well as other factors.*	*No*	*Yes – rates vary by SIC*	*No*	*Law Firms, Medical Groups*	*No*	*No*
Is over age dependent verification required?	*Yes, up to age 26*	*Yes*	*Yes, if over age 26*	*Yes, Dependents over the age of 26, require proof of disability or handicap provided by the employee at the time of enrollment.*	*Yes, age 26 is maximum*	*Yes, for disabled dependent children over the age of 26.*	*Overage dependent verification is required only above 26 for disabled children*
Maximum age/units		*Up to age 26*	*Up to age 26*	*Up to age 26*			
Do you offer Open Enrollment to DMO & DPO groups at their anniversary each year?	*Yes*	*DHMO: Yes* *DPPO: Yes*	*Yes*	*Yes*	*Open Enrollment is available for PPO*	*Yes*	*DMO: Yes* *DPO: Annual Open Enrollment on all size cases*
At Open Enrollment, do members have any restrictions (such as reduced benefits or a waiting period)?	*Members would not be subject to late entrant rules*	*DHMO and DPPO: No restrictions*	*No*	*No*	*No*	*No*	*No*
Is there a waiting period for major services for new hires (including Enrollees who initially waived the waiting period)?	*No*	*DHMO: No* *DPPO: No*	*Yes—groups with 2-9 enrolled** **Waiting period can be waived with creditable coverage*	*No*	*Our PPO has several options for benefit waiting periods including no benefit waiting period.*	*No*	*DMO: No* *DPO: No*
Are employees who reside outside of California eligible?	*Our PPO Network includes nationwide coverage. Group plans are based on the situs state of the planholder and would apply to all members.*	*DHMO: No - DHMO coverage is for CA employees only* *DPPO: Yes - there are no state restrictions and we have a national DPPO network*	*Yes*	*The plan requires employees and dependents to obtain services in the Plan's Service Areas within California.*	*Yes, for our PPO.*	*Only if worksite location is in San Diego County or Imperial County.*	*DMO: Employees residing in CA only (TX, FL, NY & NJ available, but must be quoted through underwriting)* *DPO: Yes – National Network*
Any state restrictions?		*No state restrictions*	*No state restrictions*				*No state restrictions*

DENTAL BENEFITS COMPARISON

	Nippon Life Benefits	Principal	Reliance Standard	SmileSaver/ MetLife DHMO	UnitedHealthcare	Unum
Are there any industries that are ineligible?	*Multiple Employer Trusts, Multiple Employer and Welfare Associations, Associations, Taft Hartley Welfare Funds, Employee Leasing Firms, Religious Organizations, Professional Sports Teams, Franchise Groups, and Professional Employee Organizations (PEOs) are not eligible for coverage with Nippon Life Benefits. Not for Profits require Prior HO approval.*	*Yes - Private households and non-classifiable establishments*	*YES - Dentist Offices & Labs, Association Groups/Membership Orgs/Fraternal Orgs, Trusts and Unions*	*No*	*Yes - domestic households*	*Unions, Fire and Police Depts*
Are there any industries that receive an automatic rate load?	*SIC used in rating all groups*	*Rates vary by SIC*	*YES - Jewelry-related Businesses, Automotive Dealers, Direct Selling Businesses (House to House, Street Vendors etc.), Security/Commodity Dealers, Real Estate Agents/ Developers, Beauty Salons, Funeral Services, Educational Services and Carve-Out Groups*	*No*	*Dental rates will vary by SIC*	*Rates are all dependent on industry*
Is over age dependent verification required? **Maximum age/units**	*26*	*No* *Up to age 26*	*No* *Maximum age: 23 Age 26 can be requested at time of enrollment.*	*No* *Maximum age: 26*	*No** *Maximum age/units: Full-time student not required* *Maximum age: 26*	*No*
Do you offer Open Enrollment to DMO & DPO groups at their anniversary each year?	*Option available for Open enrollment*	*Open enrollment is available for the EPO, POS and PPO plans*	*DPO: No*	*DHMO: Yes*	*DMO: Yes* *DPO: Yes*	*Yes*
At Open Enrollment, do members have any restrictions (such as reduced benefits or a waiting period)?	*No waiting period*	*No*	*No Open Enrollment. If an insured is deemed a Late Entrant**, benefits are limited to exams and cleanings for adults and exams, cleanings, and fluoride treatment for children for the first 12 months*	*No waiting period*	*DMO: No* *DPO: No - only if the group has a "wait" plan, then there would be a waiting period for major service unless there was a prior coverage*	*No*
Is there a waiting period for major services for new hires (including Enrollees who initially waived the waiting period)?	*Late entrant 24 months* *Timely entrant 12 months. There is a buy up to reduce or remove these with 5 or more lives.*	*No*	*DPO: No - waiting periods are optional, however, are available upon request through Request a Quote Virgin group: 12 month waiting period on major services. 2-9 lives have a 24 month waiting period on Ortho. 10-19 lives have a 12 month waiting period on Ortho.*	*No*	*DMO: No* *DPO: No - only if the group has a "wait" plan and member has no prior coverage*	*Normally no waiting period on dental*
Are employees who reside outside of California eligible? **Any state restrictions?**	*Yes* *Contact your Word & Brown representative*	*Yes - must enroll in the PPO. EPO and POS are available to CA residents only*	*Yes* *No state restrictions for Plan A and Plan B. Plan C not available in DE, HI, NM, SC, WA*	*No*	*DMO: No* *DPO: Yes*	*N/A*

* *All fully insured dental, vision, and group dependent life plans, whether sold on a stand-alone basis, or sold with UnitedHealthcare (UHC) fully insured or self-funded medical will follow the age 26 eligibility rules observed by UHC medical. This business rule will apply for all new and renewal policy periods which begin after September 23, 2010. Self-funded and private label dental and vision cases will be handled on a case-by-case basis at the discretion of the self-insured customer or private label business partner, respectively. Association life will be handled on a case-by-case basis.*

** *Late Entrant is someone who is eligible at initial sign up but does not sign up. A member who is covered by a spouse but loses coverage is not considered a Late Entrant.*

*** *The group's SIC will determine if a 10% load is applicable to the rates. Any groups with a SIC over 5100 is subject to a 10% load.*

DENTAL BENEFITS COMPARISON

	Aetna	Ameritas	Anthem Blue Cross	BEST Life and Health Insurance Company	Blue Shield of California	CalCPA Health
Do you offer Orthodontic Coverage?	*DMO - not covered for group 2-9 lives* *Groups 10-100* *DMO Copay - $2,300 copay* *DMO Coinsurance - $2,000 copay* *PPO - not covered for group 2-9 lives* *Included for groups 10 plus. 12 month wait then covered 50% in-network only. Ortho waiting period is waived for employees covered by the group's immediately preceding dental plan. To waive ortho wait, the group's immediately preceding plan must have covered ortho services* *Active PPO Low - Lifetime maximum $1,000* *Active PPO - Lifetime maximum $1,000* *Active PPO Plus - Lifetime maximum $1,500* *PPO Max 1000 - Lifetime maximum $1,000* *PPO Max 1500 - Lifetime maximum $1,000* *PPO 1500 - Lifetime maximum $1,000* *PPO 2000 - Lifetime maximum $1,500* *Freedom of Choice* *DMO Plan - $2,000 copay* *PPO Plan - 50% - Lifetime maximum $1,000*	*Employer-sponsored PPO/Indemnity* *Child only up to age 19.* *Voluntary PPO and Indemnity:* *Child only up to age 19.* *Ortho available when 3 or more employees with children enroll for benefits.*	*Orthodontic services covered on Dental PPO plans. All Dental Net DHMO plans cover orthodontic services. Ortho@home available.*	*Employer-Sponsored or Voluntary for PPO/Indemnity:* *Adult: Available for Employer Paid groups of 25+ enrolling $1,000 lifetime maximum per patient* *Child: Available for groups of 5+ enrolling $1,000 and $1,500 lifetime maximum per patient*	*Please refer to the Summary of Benefits for coverage level.* *Note: On plans with orthodontic coverage, some have a calendar year max, while some have a lifetime max.*	*Orthodontic services under the plan are only available to dependent children and only for groups with 6 or more participants. The benefit is 50% for both in- and out-of-network providers with a $1,000 lifetime maximum.)*
Do any of your plan cover/ include a discount for implants?	*DPO:* *Implants are covered under DPO for following plans:* *5B, 8B, 8C and 12B*	*Discounts for non-covered procedures may apply in network.*	*Implants are covered on all PPO plans. Option available for Dental Net to be included.*	*PPO & Indemnity - Mid & High Plans*	*Yes - our Smile Deluxe 2000 and Smile Deluxe Plus 2000 Plans both cover single-tooth implants*	*Covered*
Do any of your plans cover/ include a discount for teeth whitening?	*Discount benefit only*	*Discounts may apply in network*	*Yes, Dental Net*	*Discounts may apply in network.*	*No*	*The plan does not cover or provide discounts for teeth whitening*
Are 1099 employees eligible?	*No*	*No*	*No*	*No*	*No*	*No*
Out of Network Claim Adjudication	*Refer to out-of-network claim adjudication section on page 187*	*Ameritas First Plans:* *1100 Plan, PPO Fee Schedule* *1600 Plan, PPO Fee Schedule* *1600 Incentive Plan, AVG UCR* *2100 Plan, AVG UCR*	*90th of FAIR Health and MAC*	*90th UCR, 80th UCR or MAC*	*OON adjudication for DPPO is MAC or UCR depending upon plan.*	*Non-Contracted dentists are paid based on program allowance for non-Delta Dental dentists (80th percentile).*

DENTAL BENEFITS COMPARISON

	CaliforniaChoice®	California Dental Network	ChoiceBuilder®	Delta Dental	Delta Dental/ Morgan White	E.D.I.S.
Do you offer Orthodontic Coverage?	*DHMO:* *Dentegra® Smile Club - Discounts are provider specific. Please see www.dentegrasmileclub/find-a-dentist for a list of dental providers and discounts.* *SmileSaver Plan 1000 & 3000 - $1600 copay for child/$1950 copay for adult* *PPO:* *Ameritas Plan 3500, 4000 & 5000 - Optional benefit* available to groups of 5 or more eligible employees. 50% to No Annual Maximum/$1000 Lifetime Maximum. 12-month wait except for 10+ groups that meet the criteria outlined in waiting period waiver section below.* **Orthodontia is an optional benefit chosen for the entire group by the employer.*	*Plan covers Ortho treatment for both adults and children. Copays apply.*	*Delta Dental DHMO (included) no wait* *Delta Dental DPPO††† Employer sponsored: no wait Voluntary: 12 months* *Ameritas† 12 month wait††* *Anthem Blue Cross†††† Employer sponsored: no wait Voluntary: Not Available* *MetLife††††† Employer sponsored: no wait Voluntary: No Wait* *†Ameritas Dental optional ortho benefit only available to groups of 5 or more eligible employees.* *††Waiting Periods can be waived if there is a minimum of 10 employees enrolled on a ChoiceBuilder PPO dental plan and the employer has a current comparable PPO dental plan inforce. Partial and/or Full Credit given for entire initial enrolling population. Billing from 12 months ago and current bill is required at underwriting, and possibly the current carrier's Benefit Booklet.* *†††Delta Dental employer sponsored plan optional ortho benefit only available to groups of 10 or more employees, voluntary plan optional ortho benefit only available to groups of 25 or more employees.* *††††Anthem Dental optional ortho benefit only available to groups of 10 or more eligible employees.* *†††††MetLife Dental optional ortho benefit only available to groups of 10 or more eligible employees with 5 or more enrolled on PPO.* *All newly enrolled employees after initial enrollment are subject to wait periods below (Basic / Major / Ortho):* *Ameritas – Employer Sponsored or Voluntary: 3/12/24 months*	*Prepaid plan:* *Included:* *Adult: $1900 Copay; Child: $1700 Copay* *Non-Voluntary PPO:* *Adult: Available for groups of 50-99, 50% - $1000 or $1500 separate lifetime maximum per patient* *Child: Available if 10 or more employees enroll. 50%—$1000 or $1500* *separate lifetime maximum per patient. For groups of 50-99, $1000 or $1500 separate lifetime maximum per patient* *Voluntary PPO:* *Child: Available if 25 or more employees enroll. 50% - $1000 or $1500 separate lifetime maximum per patient.* *5-99 Classic Plans:* *Child: Available if 10 or more employees enroll.* *Dual Option:* *Available if at least 10 employees enroll on PPO and at least 5 employees enroll on prepaid dental plan*	*HMO:* *N/A* *PPO:* *Platinum Plan:* *Child only - 0-40-50. $1,000 lifetime max., $350 per calendar year. Separate $100 lifetime deductible* *Gold Plan:* *N/A* *Diamond Plan:* *Child only - 0-40-50. $1,500 lifetime max., $450 per calendar year. Separate $150 lifetime deductible* *Immediate Coverage Plan:* *Child only - 0-40-50. $1,500 lifetime max., $300 per calendar year. Separate $150 lifetime deductible* *The No Wait Plan:* *N/A* *Indemnity:* *Same as PPO* *Dual Option:* *N/A*	*Available on plans $1000, $1500 & $2000*
Do any of your plan cover/ include a discount for implants?	*No*	*Optional dental implant benefits are available for Advantage Plus Plans. Cost to quoted rate: 3-Tier: .75 /1.25/1.50 4-Tier: .75/1.25/1.25/1.50*	*No*	*PPO:* *Yes* *DeltaCare USA:* *No*	*No*	*No*
Do any of your plans cover/ include a discount for teeth whitening?	*DHMO:* *Covered for external bleaching only* *PPO:* *No*	*DHMO:* *Yes - copay applies for bleaching. The benefit is copay per arch or copay per tooth*	*Call your Word & Brown representative*	*PPO:* *No* *DeltaCare USA:* *Yes*	*No*	*No*
Are 1099 employees eligible?	*No*	*Yes - under certain criteria and as Voluntary. Call your Word & Brown representative for more details*	*No*	*No*	*Yes*	*Yes—if they work full-time for one employer*
Out of Network Claim Adjudication	*DHMO:* *N/A* *PPO:* *PPO 3000 and PPO 3500: MAB* *PPO 4000 and PPO 5000: UCR*	*N/A*	*See page 172*	*See page 203*	*Yes*	*80th percentile of UCR*

DENTAL BENEFITS COMPARISON

	Guardian	Health Net	Humana	Liberty Dental	Lincoln Financial Group	MediExcel Health Plan	MetLife
Do you offer Orthodontic Coverage?	*Yes, we can offer orthodontic coverage subject to some plan restrictions and is not available for groups with fewer than 5 lives.*	*HMO: HN Plus 150 and HN Plus contributory and non-contributory: $1695 Copay for adults and children* *PPO: Classic 5 plan available for qualifying groups with a $1500 orthodontia lifetime maximum*	*Yes 2+ enrolled*	*Yes, orthodontic benefits are included for Adults and Children.*	*Lincoln has flexibility to build out an ortho plan for the needs of the group.*	*Included $1200 Child $1400 Adult*	*DHMO: Included - Child/ Adult: $750-$2,410 Copay* *PPO: PPO Ortho Requirements - Ortho requires minimum of 2 eligible lives. PPO plans with 2 enrolled lives require prior ortho coverage, 10 or more enrolled lives only require prior major coverage.*
Do any of your plans cover/ include a discount for implants?	*Discounts for implants vary based on quoted benefits*	*DHMO: Yes - implant services are covered with a copayment.* *DPPO: No*	*Implant rider available 10+ enrolled*	*Yes, implant services are covered with a copayment.*	*Yes, implant coverage can be added as an optional rider*	*The Plan does not offer any coverage for implants, however the participating dental provider does offer preferential rates for implants.*	*DMO: Yes* *DPO: Yes*
Do any of your plans cover/ include a discount for teeth whitening?	*No*	*DHMO: Teeth whitening covered with a copayment* *DPPO: Not covered*	*DHMO: Covered with copay* *DPPO: Not covered*	*No*	*No*	*The Plan does not offer any coverage for teeth whitening, however the participating dental provider does offer preferential rates for teeth whitening.*	*DMO: No* *DPO: No*
Are 1099 employees eligible?	*Yes*	*No*	*Yes*	*Yes*	*Underwriting will determine during quoting*	*On a case by case basis*	*DMO: No* *DPO: No*
Out of Network Claim Adjudication	*90th UCR or MAC*	*Classic and Classic Plus plan out-of-network claim adjudication is based on 80th percentile of UCR.* *Essential plan reimburses out-of network claims based on the allowable amount applicable for the same service that would have been rendered by a network provider.*	*95th for Preventive and 90th for Basic/Major INFS = MAC*	*N/A*	*90% UCR is standard but also options for 80%, 85% or 95% UCR as well as MAC*	*N/A*	*DMO: N/A* *DPO: 90th UCR or MAC*

DENTAL BENEFITS COMPARISON

	Nippon Life Benefits	Principal	Reliance Standard	SmileSaver/ MetLife DHMO	UnitedHealthcare	Unum
Do you offer Orthodontic Coverage?	*1000 or 1500 Benefit, Child only or Children and Adult*	*Ortho Coverage is available to groups of 5+ enrolled lives.* *Dependent ortho available to age 19* *25 lives for adult/child ortho*	*Plan A and Plan C: Not Available* *Plan B:* *- For groups of 2-9: 50%, Subject to a 24-month elimination period with a $1,000 Lifetime Orthodontic Benefit* *- For groups of 10+: 50% Subject to a 12-month elimination period with a $1,000 Lifetime Orthodontic Benefit.* *Note: Elimination period will be waived on 10+ takeover parts.*	*Included Child/Adult*	*HMO:* *Adult/Child: $1895 Copay* *DPO:* *Ortho is available on specific dental PPO plans. The increments available range from $1000 -$2000.* *For all plans – Orthodontic treatment must be provided by a UnitedHealthcare panel orthodontist. Orthodontic referrals must be submitted by the patient's assigned dental provider to UHC HMO Dental.*	*PPO - Available upon request; Ortho is not available for virgin groups*
Do any of your plans cover/ include a discount for implants?	*Implants included down to 2 lives.*	*EPO, POS and PPO:* *No - but implant coverage is available as a major service or through a separate benefit rider*	*DPO:* *No*	*No*	*DMO:* *Yes* *DPO:* *Yes - implant rider available** **Inclusive of 4 preventive cleanings a year and white fillings on molars. All included in the rider.*	*Plans available that include implant coverage*
Do any of your plans cover/ include a discount for teeth whitening?	*No*	*EPO, POS and PPO:* *No - but coverage for teeth whitening is available through a separate benefit rider*	*DPO:* *No*	*No*	*DHMO:* *Yes - external bleaching only* *DPO:* *No*	*No*
Are 1099 employees eligible?	*No*	*No*	*No*	*Determined by Employer*	*United Healthcare no longer considers 1099 employees as eligible for coverage. If the group has only 1 owner, UHC requires at least one W2 Common Law Employee, who is not the spouse of the owner, to qualify the group and the W-2 needs to be enrolled.* *1099 contracted employees currently on UHC Small Group will need to be transitioned to other coverage at renewal. Outside of UHC.*	*Yes - but on a case by case basis*
Out of Network Claim Adjudication	*95th, 90th, 80th, 60th and MAC plans available*	*EPO:* *N/A* *POS/PPO:* *Either MAC/ Scheduled or 90th percentile depending on plan design*	*Out-of-network claim adjudication for non-MAC is either 80% U&C or 90% U&C. Only 80% available for Plan C*	*N/A*	*DHMO:* *No* *DPO:* *MAC + UCR* *-UCR levels of 80%, 85% or 90%*	*90th or MAC*

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CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*877-238-6200 (Spanish - Option 4)*
Commissions	*877-238-6200*
Claims	*P.O. Box 14094 Lexington, KY 40512*
Provider Services	*888-632-3862*

CALIFORNIA COVERAGE

California HMO Counties	*All counties*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*Call your Word & Brown representative*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO Plans*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are calculated based on all employee locations*
Any other rules, restrictions, or guidelines not mentioned	*None*

DUAL OPTION (MIX & MATCH)

DMO & DPPO plans can be written together. FOC & Voluntary plans are NOT included in the mix and match.

PROVIDER NETWORKS

HMO Network	*Aetna's DMO Network*
PPO Network	*Aetna's PPO Network*
Indemnity Network	*A list of providers can be found through Docfind at Aetna.com*

RATING INFORMATION

Group Size	*2-100 with medical 3-100 standalone 3-100 Voluntary*
Rate Guarantee	*12 Months*
Rates Vary by Industry?	*No*

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PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size		
	2-100 w/medical 3-100 standalone	*2-9 Voluntary*	*10-100 Voluntary*
Employees	*2-100*	*2-9*	*10-100*
For Dependents	*2-100*	*2-9*	*10-100*
% of Total Cost	*50% or 25%*	*0-49%*	*0%*

PARTICIPATION

CONTRIBUTORY			
	Group Size		
	2-9	*10-100*	*3-100 Voluntary*
Employees	*100%*	*75% (Participation is only 30% when dental is sold alongside medical.)*	*25%*
Dependents	*N/A*	*N/A*	*N/A*
NON-CONTRIBUTORY			
Employees	*100%*	*100%*	*100%*
Dependents	*N/A*	*N/A*	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

2-9 Groups: *Freedom of Choice Coinsurance, Voluntary Freedom of Choice Coinsurance*	*Scheduled Fee*
PPO $1,000, PPO $1000 Active, PPO $1500, PPO $1500 Active, Freedom of Choice Plus, Vol. PPO $1000 Active, Vol. PPO $1500, Vol. PPO $1500 Active	*UCR 80%*
PPO $2000	*UCR 90%*
10-100 Groups: *Option 1A - Copay 58, Option 3A - Copay 66, DMO Coinsurance Plan - Option 2A 100/100/60, Option 4A - Freedom of Choice, Option 5A - Freedom of Choice Active, Option 6A - Active PPO Low, Option 7A - Active PPO, Option 9A - PPO Max 1000, Option 10A - PPO Max 1500, Option 11A - PPO 1500, Option 12A - PPO 2000*	*UCR 80%*
Option 8A - Active PPO Plus (90th)	*UCR 90%*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes—if written standalone. Ineligible industries waived with prior employer-sponsored coverage*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Upon request* *Groups 6+: DE-9C, Prior Carrier Bill, Statement of Understanding and Proof of Eligibility Form – not required* **Tax documents may be requested at the discretion of the underwriter.*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*No*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Takeover coverage, where prior carrier covered major dental services, but excluded orthodontia: *Waiting period will not apply to covered major dental services, but will apply to orthodontia (if the new Aetna plan covers orthodontia) for existing members and new hires.*

Takeover coverage, where prior carrier covered both major dental services and orthodontia*: Waiting period will not apply to either major dental services or orthodontia for existing members and new hires.*

Voluntary has an enforced 12 month waiting period on major services.

SPECIAL CONSIDERATIONS

Freedom of Choice plans: members get to choose between the DMO and PPO plans on a monthly basis by calling member services. Plan changes must be made by the 15th of the month to be effective the following month.

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CONTACT INFORMATION

Customer/Member Service	*855-517-5307*	
Dental & Vision Claims	*Option 1*	*Ameritas Group Claims PO Box 82520 Lincoln, NE 68501 group@ameritas.com Fax 402-467-7336*
Billing, Enrollment Status & Add-ons/Deletes	*Option 2*	*group_assistants@ameritas.com*
Dental Provider	*Option 3*	*provider@ameritas.com*
Sales & Product information	*Contact your Word & Brown representative*	
Licensing, Compensation & Commissions	*Option 5 group_licensing@ameritas.com*	
Broker Services, Tradeshow Requests or Marketing Materials	*Option 6*	
Agent Portal Tech Support	*Option 8*	
VSP Claims	*800-877-7195 www.vsp.com*	
Add-ons/Deletes	*Fax 402-467-7338*	
Website	*www.ameritas.com*	

CALIFORNIA COVERAGE

California HMO Counties	*See LIBERTY DHMO Plans for Dual Choice Options (separate bill)*
California PPO Counties	*All*
California Indemnity Counties	*All*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, all employees.*
What is the minimum percentage of employees required in CA?	*No minimum requirement of employees located in CA; 3 if enrolled anywhere.*
What states are allowed (or not allowed) for out-of-state coverage?	*Group situs CA & NV. Out of state cover all*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All. Plan designs subject to state laws*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on Employer (situs) zip code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Ameritas First Plans may be offered Dual Choice with LIBERTY Dental DHMO Plans (separate billing and direct LDP contract) as long as minimum 3 employees in Ameritas PPO Plan(s).

See LIBERTY Dental Plan DHMO Options

PROVIDER NETWORKS

PPO Network	*Ameritas Dental Network: Ameritas.com Find an Ameritas Provider: www.ameritas.com/applications/group/findaproviderclassic*

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RATING INFORMATION

Group Size	*3-199*
Rate Guarantee	*1 year*
Rates Vary by Industry?	*No*

Rate Segments: 3-9; 10-50; 51-199 (Based on ENROLLED not eligible.)
Rate Options: Voluntary or Employer Sponsored
Rate load available to waive waiting periods.
Virgin and Non-takeover groups: option to use 1.15 rate factor (+15%) to waive waiting periods on Major and Ortho for existing and new hires.

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	3-199
Employees	*Voluntary: no minimum contribution.* *Employer Sponsored: minimum contribution of 50% for straight PPO.* *Dual Choice: minimum contribution of 50% for DHMO or PPO.*
For Dependents	
% of Total Cost	

PARTICIPATION

CONTRIBUTORY	
	Group Size
	3-199
Employees	*Straight PPO: minimum 50% or 3 enrolled, whichever is greater.* *Dual Choice: minimum 75% combined (PPO & DHMO) required with a min of 3 enrolled in PPO.*
Dependents	
NON-CONTRIBUTORY	
Employees	*All plans require a minimum of 3 PPO enrolled.*
Dependents	

OUT-OF-NETWORK CLAIM ADJUDICATION

Ameritas First PPO 1100 Plan - PPO Fee Schedule
Ameritas First PPO 1600 Plan - PPO Fee Schedule
Ameritas First PPO 1600 Incentive Plan - Average UCR
Ameritas First PPO 2100 Plan - Average UCR

Ameritas PPO Plans may be offered dual choice with LIBERTY DHMO (separate bill).

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*No*
Any ineligible industries?	*Dental offices, all marijuana related businesses.*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*May be requested if 50% or more of group is related*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No—offer to all eligible employees, no carve-outs*
Management/Non-management?	*No—offer to all eligible employees, no carve-outs*
Union/Non-union?	*Allowed with underwriting approval*
Minimum group size	*3 enrolled*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Dental plans will have a 12 month wait for Major and Ortho coverage. Waiting periods may be waived with proof of 12 month prior PPO, DHMO or EPO benefits.

Virgin and Non-Takeover groups: option to use a 1.15 rate factor (+15%) to waive waiting period on major and Ortho for existing and new hires.

SPECIAL CONSIDERATIONS

Discounts up to 10% for eyewear at Walmart. Discounts at Walmart and Sam's Club for prescriptions.

Reimbursement is available for emergency dental care needed while traveling abroad. Ameritas partners with AXA to locate credible provider care for members traveling around the globe, and reimburses for covered procedures.

Simple Add-ons:
LASIK Advantage and SoundCare available for groups with a minimum of 10 or more enrolled lives

Anthem BlueCross

CONTACT INFORMATION

Member Support, Customer Service, Claims, Commissions & Billing	*Telephone: 855-854-1429* *Hours: 8:00 a.m. to 6 p.m. PST* *(Monday–Friday)*
Broker Services	*800-678-4466* *casgbrokerservices@anthem.com* *Anthem Connect* *connect@anthem.com* *877-567-1802*

CALIFORNIA COVERAGE

California HMO Counties	*Dental Net is available in these counties: Alameda, Contra Costa, Fresno, Los Angeles, Marin, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Solano and Sonoma. Dental Net has limited availability in these counties: El Dorado, Kern, Kings, Monterey, Placer, Riverside, San Mateo, Santa Cruz, Tulare and Ventura.*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*PPO: Yes* *DHMO: No*
What is the minimum percentage of employees required in CA?	*At least 51% of all eligible employees must be employed in California.*
What states are allowed (or not allowed) for out-of-state coverage?	*PPO: All States* *DHMO: CA only*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on the employer's ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Dual Option Dental requires a minimum of 5 eligible, 2 enrolled in each plan (PPO ortho requires 5 enrolled). Dual Option defined as 1 PPO/1 DHMO or 2 PPO plans.

PROVIDER NETWORKS

PPO	*Dental Complete*
DHMO	*Dental Net network*
Indemnity	*N/A*

Anthem BlueCross

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*DHMO: 24 months* *PPO: 24 months*
Rates Vary by Industry?	*Please see plan specific EOC*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size		
	Traditional Option	*Fixed-Dollar Option*	*Voluntary Dental 5-50*
Employees	*N/A (no employer contribution required as long as group meets participation.*	*N/A (no employer contribution required as long as group meets participation.*	*Voluntary Plan would be used when participation cannot be met, voluntary requires only 5 to enroll.*
For Dependents	*N/A*	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	Dental Prime and Complete	*Voluntary Dental 5-100*
Employees	*2-4: 65% with a minimum of 2 enrolled.* *5-100: 25% with a minimum of 2 enrolled.*	*Minimum 5 enrolled*
Dependents	*N/A*	*N/A*
NON-CONTRIBUTORY	*2-100*	
Employees	*2-4: 65% with a minimum of 2 enrolled.* *5-100: 25% with a minimum of 2 enrolled.*	*N/A*
Dependents	*N/A*	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

PPO: 90th of FAIR Health and MAC
DHMO: There is no out-of-network for DHMO plans by nature of the definition of DHMO.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes, Dental Offices and Personal Households. See U/W guide for more details.*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Carve outs are not allowed.*
Management/Non-management?	*Carve outs are not allowed.*
Union/Non-union?	*The group must be actively engaged in a business or service.* *On at least 50% of its working days during the previous calendar quarter or calendar year, the group employed at least one, but not more than 50, eligible employees, the majority of whom were employed within this state.* *The group was not formed primarily for purposes of buying a health care plan.* *A bona fide employer-employee relationship exists.* *A copy of the Union Roster will be required from the employer identifying Union members*
Minimum group size	*2-100* *Note: Groups that exceed 50 employees (combined number of union and nonunion employees) may be considered for large group.*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Contact your Word & Brown representative.

SPECIAL CONSIDERATIONS

The Dental Complete plan provides an extra cleaning or periodontal maintenance for pregnant members or members living with diabetes, additional conditions included. See certificate of coverage for details.

Members enrolled in our Dental Complete plan are automatically enrolled in our International Emergency Dental Program that provides emergency dental coverage while traveling outside the country for business or pleasure.

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CONTACT INFORMATION

Member Support, Customer Service & Commissions	*800-433-0088* *cs@bestlife.com*
Sales & Product Information	*800-237-8543*
Quote Requests	*quotes@bestlife.com*
Billing	*BEST Life and Health Insurance Co.* *P.O. Box 19721* *Irvine, CA 92623-9721*
Claims	*BEST Life and Health Insurance Co.* *P.O. Box 890* *Meridian, ID 83680* *800-433-0088* *Fax 208-893-5040* *Email: cs@bestlife.com*
Add-ons/Terminations	*Fax: 949-724-1603* *Email: changes@bestlife.com* *Online Broker Portal: https://www.bestlife.com/brokers/*
Website	*www.bestlife.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All counties*
California Indemnity Counties	*All counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*There is no minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*All states allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO in 14 states. Indemnity in 39 states.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on CA employer ZIP Code.* *Note: Rates are blended for groups with more than 50% out of state.*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Boxes containing a number indicate that these coordinate plans offered by this carrier can be written together to create a dual option package. The number indicates the minimum enrollment required on each of the coordinate plans. Blank boxes indicate which plans cannot be written together

BEST PPO & IndemnityPlus		
	PPO (All)	**IndemnityPlus (All)**
PPO Dental	*5*	*5*
IndemnityPlus	*5*	*5*

Minimum 10 employees must enroll in order for group to be eligible for Dual Option. A minimum of 5 must enroll on either plan.

PROVIDER NETWORKS

PPO and Indemnity Networks	*First Dental Health (CA only)* *www.firstdentalhealth.com* *DenteMax (National)* *www.dentemax.com* *Please note: BEST Life offers access to both networks for PPO and Indemnity plans*

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RATING INFORMATION

Group Size	*Employer-Sponsored: 2+ Voluntary: 5+*
Rate Guarantee	*1 year; 2 year rate guarantee for groups of 10+ employees enrolling when available.*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	Employer-Sponsored 2+	*Voluntary Plans 5+*
Employees	*50%*	*N/A*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

VOLUNTARY		
	Group Size	
	2-4	*5+*
Employees	*N/A*	*20% On groups where Employer contributes 100%, 100% participation required*
	N/A	*N/A*
EMPLOYER-SPONSORED		
Employees	*100%*	*60% On groups where employer contributes 100%, 100% participation required.*
Dependents	*N/A*	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Three options available:
1. *90th UCR.*
2. *80th UCR.*
3. *MAC*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes—Dental Offices*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No—only required for groups enrolling less than 5 employees.*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes—if group has a carve out in place with prior dental carrier. (Minimum of 5 enrolling required)*
Management/Non-management?	*Yes—if group has carve out in place with prior dental carrier. (Minimum of 5 enrolling required)*
Union/Non-union?	*No*
Minimum group size	*Minimum of 2 enrolling employees for employer-sponsored plans only, regardless of prior coverage. Waiting periods may apply.*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Employer Sponsored:
No waiting period for groups of 10 or more employees enrolling.

5-9 Enrolled
12 month waiting period on major services waived, but proof of 12 consecutive months of comparable prior group coverage required.

Voluntary
No waiting period for groups of 10 or more employees enrolling.

SPECIAL CONSIDERATIONS

- *Any voluntary group that can demonstrate a 61% participation or greater employee enrollment rate will be eligible to have the lower Employer Contributory rates as a reward*
- *Implants covered in mid and high plans.*
- *Mid-month Effective Dates - 1st of month and 15th of month effective dates are offered.*
- *Supplemental Dental Accident Benefit - Covers up to $1,000 per accident to sound and natural tooth. Does not count toward annual maximum.*
- *Children's Good Vision Benefit - Covers 50% of eligible expenses for dependent children with ortho coverage.*
- *Bundling Discounts - Save an additional 2-5% on dental with purchase of vision and/or life.*

BEST Life™
BEST Life and Health Insurance Company

blue of california

CONTACT INFORMATION

Member Support, Customer Service & Commissions	*Producer Services* *Commissions/BOR Changes* *DPPO Member Services* *DHMO Member Services* *Dental Claim Forms* *Employer Services* *Enrollment Changes:*	*800-559-5905* *800-559-5905* *888-702-4171* *800-585-8111* *888-702-4171* *800-559-5905* *Blueshieldca.com/employer*
Dental Claims	*Blue Shield* *PO Box 272590* *Chico, CA 95927-2590*	
Add-ons/Deletes	*Fax 209-367-6475 or EC+ (Employer Connection Plus)*	
Broker Services & Licensing/Contracting	*800-559-5905*	
Billing Address	*Blue Shield of California: File 55331* *Los Angeles, CA 90074*	
Enrollment & Billing Status	*800-325-5166*	
Provider Services	*888-702-4171*	

CALIFORNIA COVERAGE

California DHMO Counties	*Alameda, Butte, Contra Costa, El Dorado, Fresno, Kern, Los Angeles, Marin, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Ventura and Yolo*
California DPPO Counties	*All Counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51% of the employees must live and work in California*
What states are allowed (or not allowed) for out-of-state coverage?	*Blue Shield's National network has providers in all 50 states*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All of Blue Shield's DPPO plans are available*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on the California employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Dual Option (choose from any two plans) is available to groups of 1 or more eligible employees

Non-Voluntary or Non-Voluntary + Voluntary Dual Option:
Minimum 50% employer contribution and minimum 65% participation

Triple Option (Choose from the following):
*Any 2 HMO's with any one PPO, any 2 HMO's with any one INO, any 3 HMO's or *any 2 PPO's with any one HMO, *any 2 INO's with any one HMO or *any 1 PPO with any 1 INO and any 1 HMO. Available to groups of 1 or more eligible employees.*

* *Triple option: Any 2 PPO's with any one HMO, any 2 INO's with any one HMO or any 1 PPO with any 1 INO and any one HMO may only be offered when written with Blue Shield small group medical plans. All other triple choice options are available with or without Blue Shield small group medical plans.*

PROVIDER NETWORKS

DHMO Network	*Blue Shield of California* *Dental HMO*
DPPO Network	*Blue Shield of California* *Dental PPO*

blue of california

blue of california

RATING INFORMATION

Group Size*	*1-50; 51-100*
Rate Guarantee	*2 year rate guarantee*
Rates Vary by Industry?	*No*

* *"Eligible" employee count should be used relative to which rate table to apply; the 1-50 rate table or the 51-100 rate table*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	1-100 (Single, Dual or Triple Option)	*1-100 Voluntary*
Employees	*50% of lowest cost offered plan*	*N/A*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	1-100 (Single, Dual or Triple Option)	*1-100 Voluntary*
Employees	◆◆ *65%†*	*Minimum of 1 enrolled*
Dependents	*N/A*	*N/A*
NON-CONTRIBUTORY		
Employees	*100%*	*N/A*
Dependents	*N/A*	*N/A*

◆◆ *Those covered by other employer sponsored benefits are NOT considered eligible in calculating participation.*

† *25% participation promotion available for groups of 5 or more enrolling. (Promotion end date at the discretion of Blue Shield). A minimum of 5 and 25% participation must be enrolled on a Blue Shield of California plan. Healthcare exchanges are not eligible for this promotion. Refusals are required for all eligible employees not enrolling in the Blue Shield plans(s); unless dental plans are written without Blue Shield medical plans. Blue Shield must be the sole carrier for dental, vision and life insurance plans.*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes, 8811 Private Households*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Yes, DE9C is required*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*Follow medical guidelines*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

DHMO	*No waiting period*
DPPO	*No waiting period*
Indemnity	*N/A*

SPECIAL CONSIDERATIONS

A group may add dental coverage off Anniversary at any time if the group's medical coverage is being recertified for eligibility. Groups can change to a different plan only at the anniversary date of the Blue Shield medical plan coverage or the anniversary date of the Blue Shield standalone dental plan coverage.

Retirees are not eligible.

OUT-OF-NETWORK CLAIM ADJUDICATION

DHMO	*N/A*
DPPO	*MAC, U80 and U85. Refer to Summary of Benefits for details.*

CalCPA Health

Health plans for CPAs since 1959

CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*877-480-7923* *calcpahealth@calcpahealth.com*
Commissions	*714-567-4390*
Claims	*Delta Dental: 1-800-765-6003*
Fax (Add-ons/Deletes)	*877-237-4519* *calcpahealth@calcpahealth.com*

CALIFORNIA COVERAGE

California HMO Counties	*Coverage offered in all California counties*
California PPO Counties	*N/A*
California Indemnity Counties	*Coverage offered in all California counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51% of the group's employees must reside in California*
What states are allowed (or not allowed) for out-of-state coverage?	*All states allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Based on CA Employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*Group must also have medical coverage with CalCPA*

DUAL OPTION (MIX & MATCH)

Dual option offerings with other carriers, including Delta Dental, are not allowed.

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*Delta Dental Plus Premier*
Indemnity Network	*N/A*

CalCPA Health

Health plans for CPAs since 1959

RATING INFORMATION

Group Size	*2+*
Rate Guarantee	*N/A*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2+
Employees	*100%*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2+
Employees	*100%*
Dependents	*100%*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Delta Dental network

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*See "Special Considerations" section*
Virgin groups eligible?	*Yes*
Quarterly/annual wage report required?	*N/A*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*No*
Minimum group size	*2+*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

Participation is available to the CA-based owners and employees of accounting firms in public practice or offering general financial services. To obtain and maintain eligibility as an employer, more than 50% of all of the employer's owners (i.e., principals, proprietors, partners, shareholders, or other owners) must be CPA Members of CalCPA, or Associate Members of CalCPA. All CalCPA Members must hold and maintain their CalCPA membership in good standing.

Groups can turn in apps for CalCPA membership with Enrollment. Membership ID# must be included on the Master App.

All employees must work 20 or 30 hours a week to enroll.

Groups must also have medical coverage with CalCPA.

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Your Health. Your Choice.®

CONTACT INFORMATION

Customer Service Center	*CaliforniaChoice*	*800-558-8003*
Member Service	*Ameritas* *Dentegra Smile Club* *SmileSaver*	*877-203-0036* *877-280-4204* *800-880-1800*
Broker Services & Commissions	*CaliforniaChoice*	*E-mail: commissions@calchoice.com* *Phone: 714-567-4390*
Dental Claims	*Ameritas (PPO):* *Ameritas* *P.O. Box 82520* *Lincoln NE 68501* *877-203-0036* *Fax 402-467-7336*	*SmileSaver (DHMO)* *Attn: Claims Dept.* *P.O. Box 30920* *Laguna Hills, CA 92654* *800-880-1800*
Add-ons/Deletes	*CaliforniaChoice* *Fax 714-558-8000*	

CALIFORNIA COVERAGE

California DHMO Counties	*Dentegra® Smile Club: All Counties* *SmileSaver Plan 1000 & 3000: All Counties*
California PPO Counties	*Ameritas Plan 3000, 3500, 4000 & 5000: All Counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51%*
What states are allowed (or not allowed) for out-of-state coverage?	*All are allowed except Hawaii*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*It is based on the employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

CaliforniaChoice has optional dental that can be offered along with medical. Employers may elect to offer one of the following to their employees:

- *All buy-up dental plans: SmileSaver DHMO 1000 & 3000, and Ameritas PPO 3000, 3500, 4000 & 5000 WITHOUT Ortho*
- *All buy-up dental plans: SmileSaver DHMO 1000 & 3000, and Ameritas PPO 3000, 3500*, 4000* & 5000* WITH Ortho*
- *All voluntary dental plans: SmileSaver DHMO 1000 & 3000, and Ameritas PPO 3000, 3500, 4000 & 5000 WITHOUT Ortho and Dentegra Smile Club***
- *All voluntary dental plans: SmileSaver DHMO 1000 & 3000, and Ameritas PPO 3000, 3500, 4000 & 5000 WITH Ortho and Dentegra Smile Club***
- *Dentegra Smile Club***

Employees may select the best dental plan to fit their needs out of those plans offered by their employer.

* *PPO plans with Ortho are only available to groups with 5 or more eligible employees.*

** *Dentegra Smile Club is included in the program at no additional cost and offers services at reduced fees. Employees and dependents (if applicable) must be enrolled for medical coverage through the CaliforniaChoice Program.*

PROVIDER NETWORKS

DHMO Network	*Dentegra Smile Club:* *Dentegra Smile Club* *DHMO Plan 1000 & 3000:* *SmileSaver Dental*
PPO Network	*PPO 3000, 3500, 4000 & 5000: Ameritas PPO*
Indemnity Network	*N/A*

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CaliforniaChoice®
Your Health. Your Choice.®

RATING INFORMATION

Group Size	*1-100*
Rate Guarantee	*12 Months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	1-100	*1-100 Voluntary*
Employees	*50% of employee only premium for lowest cost plan offered*	*0%*
For Dependents	*0%*	*0%*
% of Total Cost	*0%*	*0%*

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	1-100	*1-100 Voluntary*
Employees	◆◆ *70%*	*0%*
Dependents	*0%*	*0%*
NON-CONTRIBUTORY		
Employees	◆◆ *100%*	*0%*
Dependents	*0%*	*0%*

◆◆ *Those covered by another group plan are NOT considered eligible in calculating participation, unless the group offers to contribute 100% towards employee premium. Call your Word & Brown representative for further information.*

OUT-OF-NETWORK CLAIM ADJUDICATION

DHMO N/A

PPO Plan 3000 & 3500 - Out of network claims are paid based on MAB.

PPO Plan 4000 & 5000 - Out of network claims are paid based on U & C 80th percentile.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes—commission-only employees are eligible if they have a base a salary that is at least minimum wage and are on the quarterly/annual wage report.*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Quarterly/Annual Tax report required?	*Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*Yes – coverage available for non-union only. Group must submit union billing to underwriting for verification that all other employees have medical coverage.*
Minimum group size	*1*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

DHMO N/A

PPO For groups with 10 or more employees, the 12 month waiting period for major services will be waived for individuals who were enrolled under this employer's comparable group dental plan for 12 months or more. Groups without prior comparable dental coverage are subject to the waiting period. Credit will be given for time on the prior plan. If orthodontia was covered on comparable prior plan, credit will be given toward the 12 month ortho waiting period.

SPECIAL CONSIDERATIONS

Enrollment for spouse and children is contingent on employee enrollment.

California DENTAL
A DentaQuest Company

CONTACT INFORMATION

Customer Service, Bilingual Support, & Broker Services	*877-433-6825*
Commissions	*877-433-6825*
Claims	*877-433-6825*
Fax (Add-ons/Deletes)	*949-830-1655*

CALIFORNIA COVERAGE

California HMO Counties	*All counties except Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Mendocino, Tehama, Plumas, Glenn, Butte, Sierra, Lake, Colusa, Yuba, Nevada, Alpine, Mono, Inyo, Tulare, San Luis Obispo and Imperial*
California PPO Counties	*N/A*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*No on DHMO*
What is the minimum percentage of employees required in CA?	*Minimum group size is 2 on DHMO*
What states are allowed (or not allowed) for out-of-state coverage?	*Not applicable on DHMO*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*Not applicable on CDN DHMO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Not applicable on CDN DHMO*
Any other rules, restrictions, or guidelines not mentioned	*Not applicable on CDN DHMO*

DUAL OPTION (MIX & MATCH)

Dual Option available to groups of 2 or more eligible employees if wrapping California Dental with another carrier's PPO. Minimum 1 enrollee with California Dental Network.

Dual Option available to 1 or more eligible employees installed with preferred PPO partners such as Principal, Reliance, Mutual of Omaha, Standard and Ameritas. Otherwise California Dental Network will accept two or more eligible employees on DHMO.

PROVIDER NETWORKS

HMO Network	*CDN contracts with dental offices and pays capitation to each. It is our own network*
PPO Network	*N/A*
Indemnity Network	*N/A*

California DENTAL
A DentaQuest Company

RATING INFORMATION

Group Size	*Minimum group size is 2 enrolled*
Rate Guarantee	*12 months. Multi-year guarantees may be offered under special circumstances*
Rates Vary by Industry?	*N/A*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-50
Employees	*75% or 50% of employee and dependents combined premium*
For Dependents	
% of Total Cost	

PARTICIPATION

CONTRIBUTORY				
	Group Size			
	2-50			
	3	*4-7*	*8-10*	*11+*
Employees	*100%*	*100%-1*	*100%-2*	*75%*
Dependents				
NON-CONTRIBUTORY				
Employees	*100%*			
Dependents	*0%*			
VOLUNTARY*				
Employees	*0%*			
Dependents	*0%*			

* *Voluntary group rates apply to all groups that do not have a true employer/employee relationship as established by the IRS and groups that do not meet the contribution and participation requirements for Employer paid plans.*

OUT-OF-NETWORK CLAIM ADJUDICATION

Not applicable on CDN DHMO

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*If enrollment is not voluntary, a DE-9C is requested*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*N/A*
Management/Non-management?	*N/A*
Union/Non-union?	*N/A*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Not applicable on CDN DHMO

SPECIAL CONSIDERATIONS

Plans cover the following value add benefits:

1. *Additional teeth cleaning for adults and children beyond one every six months;*
2. *Posterior composite fillings covered;*
3. *Precious metal included in crown and bridge copayments;*
4. *Name brand crowns such as Captek, Procera, In-Ceram covered;*
5. *Bleaching covered;*
6. *Veneers covered;*
7. *Phase I Ortho covered*

Various copays apply.

Rates can be either 3 tier or 4 tier.

Multi year guaranteed.

DELTA DENTAL®

A REGISTERED TRADEMARK OF DELTA DENTAL PLANS ASSOCIATION

CONTACT INFORMATION

Customer Service & Bilingual Support	*HMO - DeltaCare USA 800-422-4234* *PPO & Dual Option* *Allied Administrators 415-989-7443*
Member Eligibility	*800-765-6003*
Commissions & Broker Services	*877-472-2669* *Fax 415-439-5861*
BOR Changes	*pwensloff@alliedadministrators.com*
Claims	*Delta Dental of California* *P.O. Box 997330* *Sacramento, CA 95899-7330* *800-765-6003*
Add-ons/Deletes	*Fax 415-439-5861* *For groups that are administered through Allied Administrators, the email address is cs@alliedadministrators.com*
Website	*www.deltadentalins.com*

CALIFORNIA COVERAGE

California HMO Counties	*All Counties*
California PPO Counties	*All Counties*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*PPO: Yes—company must be headquartered in CA* *Prepaid: No*
What is the minimum percentage of employees required in CA?	*2 primary enrollees* *DeltaCare USA* *Services must be rendered in the state where the contract is issued.*
What states are allowed (or not allowed) for out-of-state coverage?	*All states allowed for PPO*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO is offered out-of-state*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on CA employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*No*

DUAL OPTION (MIX & MATCH)

Dual Choice — PPO Plans and DeltaCare USA:

- *Groups cannot offer PPO or DeltaCare USA dual choice with another carrier.*
- *Employer contribution for employees and dependent coverage must be identical for both plans.*
- *Classic plans require a minimum enrollment of 10 eligible employees (at least two enrolled in one plan and the balance in the other).*
- *Options plans require a minimum enrollment of 50 eligible employees (at least 10 enrolled in one plan and the balance in another).*
- *PPO Voluntary requires a minimum enrollment of five eligible employees in the PPO plan and five in the DeltaCare USA plan.*
- *4 lives: 2 PPO / 2 HMO.*
- *Less than 10 primary enrollees: minimum of 2 enrolled in one plan with the remainder in the other plan. When enrolling less than 5 in PPO, use the 2-4 rates.*

PROVIDER NETWORKS

Prepaid Network	*DeltaCare USA*
PPO Network	*Delta Dental PPO*

www.deltadentalins.com

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RATING INFORMATION

Group Size	*2-99*
Rate Guarantee	*2 years (commencing in calendar year 2019)*
Rates Vary by Industry?	*Prepaid plan: No* *Non-Voluntary PPO: Yes* *Voluntary PPO: No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size					
	DeltaCare USA (DHMO) 2-99	*Classic Non-Voluntary PPO 2-99*	*Options Non-Voluntary PPO 50-99*	*Non Voluntary PPO 2-4*	*Voluntary PPO 2-4*	*Voluntary PPO 2-99*
Employees	*3 Options See Special Considerations*	*75%*	*75%*	*75%*	*0%*	*0%*
For Dependents		*0%*	*0%*	*0%*	*0%*	*0%*
% of Total Cost		*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY

	Group Size					
	DeltaCare USA (DHMO) 2-99	*Classic Non-Voluntary PPO 2-99*	*Options Non-Voluntary PPO 50-99*	*Non-Voluntary PPO 2-4*	*Voluntary PPO 2-4 Min. 2 enrollees*	*Voluntary PPO 2-99*
Employees	*3 Options See Special Considerations*	◆◆ *75%*	◆◆ *75%*	◆◆ *75%*	*Min. 2 enrollees*	*Min. 5 enrollees*
Dependents		*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
NON-CONTRIBUTORY						
Employees	◆◆ *100%*	◆◆ *100%*	◆◆ *100%*	◆◆ *100%*	*N/A*	*N/A*
Dependents	◆◆ *100%*	◆◆ *100%*	◆◆ *100%*	◆◆ *100%*	*N/A*	*N/A*

◆◆ ***Those covered by another plan are NOT considered eligible in calculating participation. In order to NOT be considered eligible, the other coverage must be a group plan. If an employee or dependent declines to enroll when they become eligible, they cannot enroll at a later date unless they show proof of loss of coverage***

OUT-OF-NETWORK CLAIM ADJUDICATION

Prepaid Plan	*No out-of-network coverage*
PPO Value, PPO Enhanced and PPO Vol	*Based on Delta Dental PPO fee allowance*
PPO Plus Premier Value, PPO Plus Premier Enhanced, PPO 1, PPO 2 and PPO 3	*For non-PPO Delta Dental dentists, out-of-network coverage is their negotiated fee. For non-Delta Dental dentists, out-of-network coverage is the lesser of the submitted fee or the fee that satisfies the majority of Delta Dental dentists for that service in the same geographical area.*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*May be eligible if not paid via 1099 – Call your Word & Brown representative*
Any ineligible industries?	*Non voluntary: Yes* *Voluntary: PPO-No* *DeltaCare USA: Yes*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Prepaid plan: No; PPO: Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes, if full time, permanent employees*
Management/Non-management?	*See footnote below**
Union/Non-union?	*See footnote below**
Minimum group size	*Same minimum group size as for non-carve out group. See chart on left*

* ***Carve-out (i.e. all types such as management, union & etc.) is available and will require employer to offer benefits to all classes of employees. Delta Dental PPO can be offered to one population such as management employees and DeltaCare USA will be offered to the remaining employees. Employer must provide DE-9C identifying the carve-out. The carved-out group will receive level 2 rates. PPO level 2 rates can be offered to management as long as no other carriers are offered to remaining employees***

WAITING PERIOD WAIVER/TAKEOVER

Prepaid plan	*No Waiting Period*
Non-Voluntary PPO	*No Waiting Period*
Voluntary PPO	*12-month waiting period applies to all covered services except D&P, sealants, simple restorations, simple extractions and dental accident. Waiting period can be waived for initial enrollees only if group had prior fee for services or comprehensive prepaid HMO coverage with no break in coverage.*

SPECIAL CONSIDERATIONS

Transferring a group from an existing Delta Dental or prepaid HMO to small group program is not allowed. Businesses enrolling with the prepaid dental HMO plan may customize their employer contribution and enrollment guidelines choosing from these three options:

A) Non-Voluntary enrollment
Minimum employer contribution is 75% of employee and dependent cost. If contribution is 100%, then all eligible employees and dependents must enroll. If contribution is less than 100%, then at least 75% of eligible employees must enroll. Minimum of 2 employees must be enrolled.

B) Voluntary Dependent enrollment*
*Minimum employer contribution is 75% of employee cost. Employer must provide payroll deduction for dependent coverage. Minimum of 2 employees must enroll but there is no dependent participation requirement. 75% of eligible employees must enroll. (*Option B rates are shown in our quote.)*

C) All-Voluntary enrollment
No minimum employer contribution but employer must provide payroll deductions for employees and dependents electing to enroll. Minimum of 2 employees must enroll.

The pregnancy enhancement for Delta Dental PPO groups now includes coverage for the following additional benefits during the year(s) in which a patient is pregnant:
1. One additional oral exam; and
2. One of the following:
- *An additional prophylaxis (D1110)*
- *Periodontal scaling/root planning, per 4 quadrant (D4341/D4342)*

A waiver form is mandatory for all employees declining Delta Dental coverage.
Deductible Rollover Credit is not available.
The following industries are ineligible:
***DeltaCare USA**: Law firms and associations; seasonal employment; high turnover[2]*
***Delta Dental PPO**: Associations and Trusts[1] (except #8661); beauty & barber shops; dentist offices, dental labs and medical labs; employment agencies; high turnover[2]; international affairs; misc. business services; misc. services not elsewhere classified; partnerships; private households; religious organizations (except churches #8661); seasonal employees (Christmas/part-time help); seasonal employees (agriculture);*
***Voluntary PPO**: All industries eligible*
[1] Management and the administrative staff of Associations and Trusts are eligible under Level 1. Use SIC Code 8741
[2] A business has "high turnover" if 20% or more of the average number of its employees during the past 12 months were newly hired for reasons other than the growth of the business.
***No Retroactive Terminations Allowed**.*

DELTA DENTAL®

A REGISTERED TRADEMARK OF DELTA DENTAL PLANS ASSOCIATION

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MORGAN WHITE GROUP

CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*888-859-3795*
Commissions & Broker Services	*800-800-1397*
Claims	*Delta Dental Insurance Company* *P.O. Box 1809* *Alpharetta, GA 30023-1809*
Fax (Add-ons/Deletes)	*601-956-3795* *Email: mwa@morganwhite.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*All Counties*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*N/A*
What states are allowed (or not allowed) for out-of-state coverage?	*States allowed: AL, DE, DC, FL, GA, LA, MS, MT, NV, NY, PA, TX, UT & WV*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO and Premier (Indemnity)*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on out-of-state ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*All enrollments must be received by the 20th of the month for a 1st of the following month effective date*

DUAL OPTION (MIX & MATCH)

Yes—PPO & Premier can be written together

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*Delta Dental PPO*
Indemnity Network	*Delta Dental Premier*

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MORGAN WHITE GROUP

RATING INFORMATION

Group Size	*1-4*
Rate Guarantee	*If the group or individual is effective January through June – group/individual will have a rate guarantee until January. If the group or individual is effective July through December – group/individual will have a rate guarantee until July. After the first year, rates may be increased every 12 months.*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	N/A
Employees	*N/A*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	N/A
Employees	*N/A*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*
VOLUNTARY*	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

PPO	*Delta Dental-approved PPO fees*
Premier® (Indemnity)	*Plan allowance based on fees that satisfy the majority of Delta Dental Dentists or the submitted fees, whichever is less*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*N/A*
Management/Non-management?	*N/A*
Union/Non-union?	*N/A*
Minimum group size	*1*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

All dental plans include a one time, non-refundable setup fee of $35, with $8 going to the broker. The broker portion of this fee will be shown on the commission statement.

DELTA DENTAL®
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MORGAN WHITE GROUP

E.D.I.S.
EMPLOYER DRIVEN INSURANCE SERVICES

CONTACT INFORMATION

Phone	*888-886-7973*
Email	*service@employerdriven.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*Yes-available for out of state employers in: Arizona, Colorado, Kansas, Nevada, South Carolina, Texas, Utah, Washington DC*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO & EPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*No minimum*
Any other rules, restrictions, or guidelines not mentioned	*All are allowed*

DUAL OPTION (MIX & MATCH)

Employer may offer all four plan options from which the employee may select.

PROVIDER NETWORKS

Indemnity Network	*N/A*
PPO Network	*DenteMax, First Dental Health*

E.D.I.S.

EMPLOYER DRIVEN INSURANCE SERVICES

RATING INFORMATION

Group Size	*2-99*
Rate Guarantee	*12 Months*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-99
Employees	*0-50% of the lowest priced plan*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-99
Employees	*75%*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

80th percentile of UCR

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?*	*Yes—excluded industries include those with SIC codes 8021 (Dentist) & 8111 (Law Office)*
Virgin groups eligible?	*Yes—subject to a twelve month wait for major benefits on Voluntary plans only*
DE-9C statements required?	*Yes*

* *The group's SIC will determine if a 10% load is applicable to the rates. Any groups with a SIC over 5100 is subject to a 10% load.*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*Must meet 75% participation rule*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

None

SPECIAL CONSIDERATIONS

This is a fully insured product. No administration fee applies.

Employer Sponsored: Employer may make one plan available or all four plans available as an option.

Voluntary: Minimum of 2 enrolled, no other participation guidelines.

Guardian®

CONTACT INFORMATION

Customer Response Unit	*(available to employees, employers and brokers)* *1-800-627-4200* *cru@glic.com*
Administration and Self-Service Portal	*(available to employees, employers and brokers)* *www.GuardianAnytime.com*

CALIFORNIA COVERAGE

California HMO Counties	*Statewide*
California PPO Counties	*We offer our PPO network in all California counties and can provide network access analysis reports for a specific group during the quoting process.*
California Indemnity Counties	*Yes, we can quote Indemnity Dental anywhere in the state of California*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, our PPO network offers nationwide coverage. Plans may be quoted to include out-of-state employees.*
What is the minimum percentage of employees required in CA?	*There are no requirements for the minimum percentage of employees in California, however to be a considered a situs, there would need to be one officer located in the state.*
What states are allowed (or not allowed) for out-of-state coverage?	*Not applicable; however, plan design is based on employer location, so some state variations may apply.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*There are some limitations and variations on what we can offer depending on the specific state regulation.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Premiums are based on the employer location. Provider services are reimbursed based on the fee schedule or reasonable and customary reimbursement, based on the provider ZIP Code.*
Any other rules, restrictions, or guidelines not mentioned	*Benefits are quoted based on state requirements.*

DUAL OPTION (MIX & MATCH)

We can offer a dual option PPO/DHMO plan to groups with 2+ lives. We can offer a High/Low PPO plan to groups with 10+ lives.

PROVIDER NETWORKS

Indemnity Network	*Guardian can offer indemnity plans.*
PPO Network	*Guardian has a PPO Dental network.*

Guardian®

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*1 year*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-100
Employees	*No limitations*
For Dependents	*No limitations*
% of Total Cost	*No limitations*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-100
Employees	*No limitations*
Dependents	*No limitations*
NON-CONTRIBUTORY	
Employees	*No limitations*
Dependents	*No limitations*

OUT-OF-NETWORK CLAIM ADJUDICATION

Non-contracted dentists are reimbursed using reasonable and customary for the dentist's ZIP Code area. We use the 90th percentile of reasonable and customary as our standard and can pay claims using different percentiles of reasonable and customary, such as the 50th, 70th, 75th, 80th, 85th or 95th percentile at the planholder's preference.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*Yes, generally subject to UW review*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Wage & tax reports statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Dependent on case.

SPECIAL CONSIDERATIONS

Each case stands on its own merits and will be evaluated separately. Any special considerations will be provided during the quoting stage.

Health Net®
Dental

CONTACT INFORMATION

Customer Service, Member Service & Claims	*866-249-2382 (Spanish - Option 2)*
Fax (Add-ons/Deletes)	*916-935-4420* *Email: enrollmentunit_north@healthnet.com*
Member Eligibility	*800-224-8808 (Option 3)*
Commissions	*800-448-4411 (Option 4)*
BOR Changes	*Contact the assigned Health Net Account Manager*
Website	*yourdentalplan.com/healthnet*
Dental Provider	*yourdentalplan.com/healthnet to find DHMO and DPPO providers*
Sales & Product Information	*Contact your Account Manager or Sales Executive*

CALIFORNIA COVERAGE

California HMO Counties	*All Counties except: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Imperial, Kings, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne and Yuba*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: DHMO plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes - DPPO is available for out-of-state employees*
What is the minimum percentage of employees required in CA?	*51%*
What states are allowed (or not allowed) for out-of-state coverage?	*DPPO allowed in all states; DHMO coverage is available in California only*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO Only*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on CA employer ZIP code*
Any other rules, restrictions, or guidelines not mentioned	*Refer to dental underwriting guidelines for more info*

DUAL OPTION (MIX & MATCH)

Dual option available – Groups may select 1 DHMO and 1 DPPO with a minimum of 4 active subscribers, and 2 on each plan. Groups may select 2 DHMO or 2 DPPO plans with a minimum of 10 active subscribers, with a minimum of 2 on each plan. Employer paid rates require 50% employer contribution and 75% overall participation, and proof of prior coverage. Voluntary rates require a minimum participation of 75%, but no minimum employer contribution or proof of prior coverage required.

PROVIDER NETWORKS

HMO Network	*Health Net Dental*
PPO Network	*Health Net Dental*

Health Net®
Dental

RATING INFORMATION

	DHMO	PPO
Group Size	*2-100*	*2-100*
Rate Guarantee	*1 Year*	*1 Year*
Rates Vary by Industry?	*No*	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	DHMO 2-100	*DPPO 2-100*
Employees	*50%*	*50%*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	DHMO 2-100	*DPPO 2-100*
Employees	*Min. 2†*	*Min. 2††*
Dependents	*N/A*	*N/A*
NON-CONTRIBUTORY		
Employees	*Min. 2***	*Min. 2***
Dependents	*N/A*	*N/A*

◆ *Those covered by another plan are NOT considered eligible in calculating participation*
† *Employer paid DHMO rates require a minimum participation of 50% and 50% employee contribution, and proof of prior coverage.*
†† *Employer paid DPPO rates require a minimum participation of 75% and 50% employee contribution, and proof of prior coverage. Classic Plus 1 plans require a minimum of 10 enrolled employees.*
** *Voluntary rates apply to groups with less than 50% contribution and 50% participation, or to groups without proof of prior coverage.*
*** *Voluntary rates apply to groups with less than 50% contribution and 75% participation, or to groups without proof of prior coverage.*
NOTE: Classic Plus 1 plan requires a minimum of 10 enrolled employees.

OUT-OF-NETWORK CLAIM ADJUDICATION

Classic and Classic Plus plan out-of-network claim adjudication is based on 80th percentile of UCR.

Essential plan reimburses out-of network claims based on the allowable amount applicable for the same service that would have been rendered by a network provider.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes - groups without proof of prior coverage will have voluntary rates*
DE-9C statements required?	*Yes—reconciled*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*N/A*
Management/Non-management?	*N/A*
Union/Non-union?	*N/A*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

HMO *No Waiting Period*

PPO *Employer Paid DPPO Plans: No waiting period. Orthodontia is available to groups of 2-9 enrolled employees with proof of immediately prior indemnity or DPPO orthodontic coverage*

Voluntary DPPO Plans: Orthodontia is available for voluntary DPPO groups of 10 or more enrolled employees

SPECIAL CONSIDERATIONS

All employees must be covered by Workers' Compensation.

Voluntary rates apply to all DHMO and DPPO groups with no prior dental coverage regardless of the employer contribution or employee participation.

Call your Word & Brown representative for details on two employer-paid and two voluntary Health Net vision PPO plans.

Humana

CONTACT INFORMATION

Customer Service, Member Service & Claims	*1-877-877-1051*
Fax (Add-ons/Deletes)	*1-866-584-9140 (fax)*
Member Eligibility	*1-866-584-9140 (fax)*
Commissions	*1-855-330-8128*
BOR Changes	*1-855-330-8128* *agencymgt@humana.com*
Website	*https://www.humana.com*
Dental Provider	*https://www.humana.com/finder/dental*
Sales & Product Information	*easyrate@humana.com*

CALIFORNIA COVERAGE

California HMO Counties	*All counties*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

NOTE: DHMO plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*Min. of 1 enrolled in Home Office/CA*
What states are allowed (or not allowed) for out-of-state coverage?	*All states are allowed except Oregon, Washington, Montana, Wyoming, Rhode Island and Delaware.** **Please contact Humana for more details.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO** *HMO varies by state, please contact Humana Sales rep for availability*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Employer ZIP code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Multiple choices available for Employers
- *10-24 enrolled - Dual option DHMO/DPPO or DPPO with varying co-insurance*
- *25+ enrolled - Triple options available with DHMO/DPPO/DPPO*

PROVIDER NETWORKS

HMO Network	*Liberty Dental Network in CA*
PPO Network	*Humana Dental Network*

Humana

Humana

RATING INFORMATION

	DHMO	DPO
Group Size	*2-100*	*1-100*
Rate Guarantee	*12 month / 24 months**	*12 month / 24 months**
Rates Vary by Industry?	*Yes*	*Yes*

**24 month guarantee available for +3% rate increase*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	1-100
Employees	*No limitations*
For Dependents	*No limitations*
% of Total Cost	*No limitations*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	1-100
Employees	*50% (min 2)*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*Min 2*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*SIC Code 8021 - Offices & Clinics of Dentists*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*2*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

N/A

CONTACT INFORMATION

Member Services	*888-703-6999*
Client Services	*888-273-2997 ext. 162*
Billing address	*LIBERTY Dental Plan* *P.O. Box 26110* *Santa Ana, CA 92799-6110*
Commissions	*nationalaccounts@libertydentalplan.com*
Claims	*nationalaccounts@libertydentalplan.com*
Provider Services	*nationalaccounts@libertydentalplan.com*

CALIFORNIA COVERAGE

California HMO Counties	*Alameda, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquín, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo*
California PPO Counties	*N/A*
California Indemnity Counties	*N/A*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*LIBERTY does not allow out-of-state coverage*
What is the minimum percentage of employees required in CA?	*Minimum 2 Employees*
What states are allowed (or not allowed) for out-of-state coverage?	*N/A*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*N/A*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*LIBERTY does not allow out-of-state coverage*
Any other rules, restrictions, or guidelines not mentioned	*None*

DUAL OPTION (MIX & MATCH)

May be offered with Ameritas First Plus PPO Plans, minimum 2 employees on LDP and up to two LDP plans may be offered in same group with minimum of 2 employees in each plan and minimum 3 in Ameritas PPO Plan(s). Note, there is separate billing.

PROVIDER NETWORKS

HMO Network	*CA Select Network*
PPO Network	*N/A*

RATING INFORMATION

Group Size	*2-300 lives*
Rate Guarantee	*Rates are guaranteed for 24 months.*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2+
Employees	*No minimum*
For Dependents	*No minimum*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2+
Employees	*2+*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*2+*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Out-of-network coverage is not allowed.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Private Households*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*We will allow up to two plans in one group as long as minimum 2 employees in each group.*
Management/Non-management?	*We will allow up to two plans in one group as long as minimum 2 employees in each group.*
Union/Non-union?	*We will allow up to two plans in one group as long as minimum 2 employees in each group.*
Minimum group size	*Minimum of 2 employees*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

No waiting periods. Ortho takeover offered when in progress and with prior DHMO coverage.

SPECIAL CONSIDERATIONS

N/A

Lincoln Financial Group®

CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*844-258-5922*
Commissions	*800-423-2765* *Brokers enter prompt 4*
Claims	*PPO Claims* *Dental Claims Processing Center* *PO Box 614008* *Orlando, FL 32861* *Fax: 877-843-3945*
Provider Services	*800-423-2765* *Providers: prompt 3* *Payer ID Number: CX061* *To check claim status, email: claims@lfg.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All*
California Indemnity Counties	*All*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, for our PPO product.*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*For PPO, all states are allowed.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO and Indemnity is offered in all states for out-of-state employees.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Out of state ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

Lincoln has flexibility to offer High/Low plans.

PROVIDER NETWORKS

PPO Network	*Lincoln Connect* *PPO Claims* *Dental Claims Processing Center* *PO Box 614008* *Orlando, FL 32861* *Fax: 877-843-3945* *1-800-423-2765* *Providers: prompt 3* *Payer INumber: CX061*

Lincoln Financial Group®

Lincoln Financial Group®

RATING INFORMATION

Group Size	*2-99 lives*
Rate Guarantee	*1 year guarantee, renewal rates caps*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-99
Employees	*0*
For Dependents	*0*
% of Total Cost	*0*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-99
Employees	*25%*
Dependents	*0%*
NON-CONTRIBUTORY	
Employees	*100%*
Dependents	*0%*

OUT-OF-NETWORK CLAIM ADJUDICATION

Dentist Office will typically file claim on claimants behalf.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Dental Office; Private Households*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*2-99 lives*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Our proposal will outline if waiting periods are waived.

SPECIAL CONSIDERATIONS

N/A

MediExcel HEALTH PLAN

CONTACT INFORMATION

Customer Service	*619-365-4346*
Adds/Terms	*619-421-1659* *applications@mediexcel.com*
Commissions, Broker Services & Claims	*619-421-1659*
BOR Changes	*619-421-1659* *sales@mediexcel.com*
Claims	*MediExcel Health Plan* *750 Medical Center Court, Suite 2* *Chula Vista, CA 91911*
Licensing/Contracting	*619-365-4346*
Website	*www.mediexcel.com*
Service Center	*619-365-4346*
Enrollment & Billing Status and Sales & Product Information	*619-421-1659*
Dental Provider	*619-365-4346*
Broker Relations, Tradeshow Requests, or Marketing Materials	*619-421-1659*
Agent Portal Tech Support	*619-421-1659*
Bilingual Support	*619-365-4346*
Member Eligibility	*619-365-4346*

CALIFORNIA COVERAGE

California Counties	*D100 - San Diego County; Imperial County* *D200 - San Diego County; Imperial County*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes - Only if worksite is in San Diego County or Imperial County*
What is the minimum percentage of employees required in CA?	*Minimum of 1 enrollee as long as offered to all eligible employees*
What states are allowed (or not allowed) for out-of-state coverage?	*CA, but only if worksite is in San Diego County or Imperial County.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*N/A*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Employer Zip Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

PROVIDER NETWORKS

DHMO Network	*MediExcel Dental Plan Network*

MediExcel HEALTH PLAN

RATING INFORMATION

Group Size	*1 minimum, no maximum (Stand-alone or with Medical)*
Rate Guarantee	*DHMO - 12 Months*
Rates Vary by Industry?	*DHMO - No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	1+
Employees	*0%*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	1+
Employees	*1 enrollee*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*1 enrollee*
Dependents	*1 enrollee*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Minimum group size	*1*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

N/A

MetLife®

CONTACT INFORMATION

Member Services	*800-275-4638*
Commissions/Group Benefits	*888-653-8325* *ask4met@metlifeservice.com*
Claims	*MetLife Dental Claims* *P.O. Box 981282* *El Paso, TX 79998* *888-466-8673* *Claims Fax: 859-389-6505*
Fax (Add-ons/Deletes)	*888-505-7446* *Irvine_service@metlifeservice.com*

CALIFORNIA COVERAGE

California Prepaid DHMO Counties	*All Counties except: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Inyo, Imperial, Kings, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity and Tuolumne*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes* *PPO: National Network* *DHMO: Florida, New Jersey, New York and Texas*
What is the minimum percentage of employees required in CA?	*DHMO & PPO: Small Group: 75% min must reside in CA. If group has more than 25% of employees residing outside of CA proposal must be provided by underwriting dept.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*DHMO Plans: FL, NJ, NY & TX* *PPO Plans: All*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*California employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*No*

DUAL OPTION (MIX & MATCH)

These coordinate plans offered by this carrier can be written together to create a dual option package.

	Any DHMO Plan
Any PPO Plan	●

Dual Option Availability:
Employer Sponsored PPO/PPO: Minimum of 50 eligible lives, minimum of 10 enrolled in each plan.
ER Sponsored PPO/DHMO:
Minimum of 10 eligible lives
- 10-24: minimum of 5 enrolled in each plan
- 25-49: minimum of 5 enrolled in DHMO and 10 enrolled in PPO
- 50-99: minimum of 5 enrolled in DHMO and 20 enrolled in PPO
Voluntary PPO/DHMO:
Minimum of 25 eligible lives
- 25-49: minimum of 5 enrolled in DHMO and 10 enrolled in PPO
- 50-99: minimum of 5 enrolled in DHMO and 20 enrolled in PPO

PROVIDER NETWORKS

HMO Network	*MetLife Dental* *www.metlife.com/dental*
PPO Network	*MetLife Dental - PDP Plus Network* *www.metlife.com/dental*
Vision Network	*MetLife Vision/VSP CHOICE* *www.metlife.com/vision*

MetLife®

RATING INFORMATION

	DHMO	PPO*	Dual Option
Group Size (enrolled)	*Min. 5*	*Min. 2*	*See dual option availability requirements on previous page*
Rate Guarantee	*1 Year*	*1 Year*	*1 Year*
Rates Vary by Industry?	*No***	*No***	*No***

* *Plans with a Calendar Year Max. of $2,000 are available for 2-99 lives.*
** *Rates are driven by Industry code (SIC) and group location.*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	ER Sponsored 2-99	*Voluntary 2-99*
Employees	*0*	*0*
For Dependents	*N/A*	*N/A*
% of Total Cost	*50%*	*49% or less*

PARTICIPATION

CONTRIBUTORY	
	Employer Sponsored - Employer must contribute 50% or more
DHMO	*Minimum 5 and 30% of eligible*
PPO*	*2-4: 100% of eligible; 5-99: minimum 5 and 75% of eligible*
Dual Option (PPO/DHMO)	*Minimum of 10 eligible; 5 enrolled in DHMO, 5 enrolled in PPO for 10-24, 10 enrolled in PPO for 25-49 eligible, 20 enrolled in PPO for 50-99 eligible*

* *Plans with a Calendar Year Max. of $2,000 are available for 2-99 lives*

VOLUNTARY	
	Voluntary-Employer contribute 0-49% of Employee premium
DHMO	*Minimum 5 and 30% of eligible*
PPO*	*2-4: 100% of eligible; 5-99: minimum 5 and 75% of eligible*
Dual Option (PPO/DHMO)	*Minimum of 10 eligible; 5 enrolled in DHMO, 5 enrolled in PPO for 10-24, 10 enrolled in PPO for 25-49 eligible, 20 enrolled in PPO for 50-99 eligible*
Vision	*Minimum 5*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Yes - Excluded SIC's: 8021, 8072, 8200-8299, 8811, 9999*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes†*
Management/Non-management?	*Yes†*
Union/Non-union?	*Yes†*
Minimum group size	*PPO* - 2 enrolling employees* *Vol. PPO* - 2 enrolling employees* *DHMO - 5 enrolling employees*

† *MetLife must be the only carrier and 100% of eligible carve out population must enroll*
* *Plans with a Calendar Year Max. of $2,000 are available for 2-99 lives*

WAITING PERIOD WAIVER/TAKEOVER

DHMO: *No waiting period*
PPO: *No waiting period*

SPECIAL CONSIDERATIONS

Dental rates are available on a 4 tier basis.

All rates include annual open enrollment.

OUT-OF-NETWORK CLAIM ADJUDICATION

DHMO: *N/A*
DPPO: *Southern California: 90th UCR or MAC*
Northern California: 90th UCR or MAC

Call your Word & Brown representative for details

Nippon Life Benefits®

CONTACT INFORMATION

Customer Service, Bilingual Support, & Broker Services	*800-374-1835 (English)*
Claims	*800-374-1835 (English)*
Provider Services	*800-374-1835 (English)*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*CA-issued policies cover employees in all states*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*CA unless they have multiple locations*
Any other rules, restrictions, or guidelines not mentioned:	*No*

DUAL OPTION (MIX & MATCH)

Can offer Dual option with 10 enrolled employees. Only require 1 employee in second plan.

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*ADA* *FDH*
Indemnity Network	*N/A*

Nippon Life Benefits®

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*1 or 2 years*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-100
Employees	*50%*
For Dependents	*No Minimum*
% of Total Cost:	*No Minimum*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-100
Employees	*25%*
Dependents	*No Minimum*
NON-CONTRIBUTORY	
Employees	*25%*
Dependents	*No Minimum*

OUT-OF-NETWORK CLAIM ADJUDICATION

95th, 90th, 80th, 60th and MAC available

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*No for union groups*
Minimum group size	*2+*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

SPECIAL CONSIDERATIONS

Principal℠

Insurance underwritten by Principal, a member of the Principal Financial Group®.

CONTACT INFORMATION

Customer & Broker Services	*800-843-1371*
Adds/Terms	*GroupBenefitsAdmin@principal.com*
Commissions	*800-388-4793*
BOR Changes	*Email BOR Change Request Form to commissions.group@principal.com*
Claims	*800-245-1522*
Billing Address	*Principal Life Group P.O. Box 14513 Des Moines, IA 50306-3513*
Website	*www.principal.com*

CALIFORNIA COVERAGE

California Counties	*Alameda, Butte, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura & Yolo*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes—coverage is available for out-of-state employees through a PPO plan. However, rates with out-of-state employees may vary. Please contact your Word & Brown representative.*
What is the minimum percentage of employees required in CA?	*Contact your Word & Brown representative. If quoting EPO or POS, all employees must reside in California*
What states are allowed (or not allowed) for out-of-state coverage?	*All states available. Contact your Word & Brown representative*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO—contact your Word & Brown representative*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Contact your Word & Brown representative*
Any other rules, restrictions, or guidelines not mentioned	*Contact your Word & Brown representative*

DUAL OPTION (MIX & MATCH)

Dual Choice: Can be written with another carrier's DHMO, minimum 5 lives or 20% (whichever is greater); rate load of 8% will be applied. Please contact your Word & Brown representative.

PROVIDER NETWORKS

EPO Network	*First Dental Health EPO*
POS Network	*Principal POS*
PPO Network	*Principal Plan Dental*

Principal℠

Insurance underwritten by Principal, a member of the Principal Financial Group®.

Principal℠

Insurance underwritten by Principal, a member of the Principal Financial Group®.

RATING INFORMATION

Group Size	*3-100**
Rate Guarantee	*1 Year*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size		
	*3-100**		
	Non-contributory	*Contributory*	*Voluntary*
Employees	*100%*	*50–99%*	*0-49%*
For Dependents	*0%*	*0%*	*0%*
% of Total Cost	*N/A*	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	*3-100**
Employees	*50%*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*100%*
Dependents	*N/A*
VOLUNTARY	
Employees	*20%*
Dependents	*N/A*

**Plans with child ortho require a minimum of 5 enrolled employees*

OUT-OF-NETWORK CLAIM ADJUDICATION

POS/PPO: Either MAC/Scheduled or 90th percentile depending on Plan design.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Yes—8811 (private households) and 9999 (non-classifiable establishments)*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*5 enrolled lives*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

No Benefit Waiting Periods apply. If group wants to include a waiting period, call your Word & Brown representative for a custom quote.

SPECIAL CONSIDERATIONS

EPO providers - no benefits are available when visiting a non-network provider.

Enhanced Benefits Provisions: 3% load for composite fillings on molars; 2% load for porcelain facing on crowns.

For groups over 100 lives, please contact your Word & Brown representative.

Principal℠

Insurance underwritten by Principal, a member of the Principal Financial Group®.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Smart Choice

CONTACT INFORMATION

Member Support, Customer Service, Commissions	*Dental 800-659-2223* *LTD & STD 800-351-7500*
Claims	*P.O. Box 82510* *Lincoln, NE 68501* *800-497-7044*
Fax (Add-ons/Deletes)	*402-309-2583*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*N/A*
California Indemnity Counties	*All Counties*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*All states allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*Indemnity with nationwide passive PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on the firm's home office (i.e. where billed)*
Any other rules, restrictions, or guidelines not mentioned	*No*

DUAL OPTION (MIX & MATCH)

N/A

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*Utilizes both Ameritas and Principal PPO Network*

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Smart Choice

RATING INFORMATION

Group Size	*2-19*
Rate Guarantee	*1 or 2 Years*
Rates Vary by Industry?	*Yes, some loaded industries considered higher risk*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-19
Employees	*2*
For Dependents	*No requirement*
% of Total Cost	*No requirement*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-19
Employees	*2 eligible employees - both must be insured*
Dependents	*3 to 5 eligible employees - all but one must be insured* *6 to 9 eligible employees - all but two must be insured* *10 to 19 eligible employees - 75% must be insured* *100% enrolled if employer paid, unless employee has proof of existing coverage elsewhere*
NON-CONTRIBUTORY	
Employees	*100% of eligible employees or may carve out or class out*
Dependents	

OUT-OF-NETWORK CLAIM ADJUDICATION

Indemnity: Out of network claim adjudication for non-MAC is either 80% U&C or 90% U&C

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Yes*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*Down to 3 insured employees; If sold with 2 other lines of coverage down to 2 insured employees, Life STD LTD CI or AI*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Plan A and Plan B:
- For groups of 2-19: 12 month wait for Major Services, which can be waived on takeover groups with similar coverage in force for at least 12 months prior to the effective date. 10% rate load applied to takeover groups.

Plan C:
- No waiting periods or loads for takeover

SPECIAL CONSIDERATIONS

For Plan C Only: Reduced Participation Option - requires 50% participation with a minimum of 5 lives insured.

SmileSaver℠

Provided by Safeguard Health Plans, Inc., A MetLife Company

CONTACT INFORMATION

Customer Service, Member Service & Bilingual Support	*SmileSaver Dental Plan/MetLife Customer Service* *800-880-1800*
Group Billing & Eligibility	*DHMO—SmileSaver Dental Plan/MetLife: 800-750-4303* *Fax: 949-360-3695* *groupb&e@metlife.com*
Broker Information	*800-275-4638* *Broker_Change@metlife.com*
Billing Address	*DHMO-SmileSaver Dental Plan/MetLife:* *Attn: Billing* *PO Box 101560* *Pasadena, CA 91189*

CALIFORNIA COVERAGE

California DHMO Counties	*All Counties except: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Inyo, Imperial, Kings, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity and Tuolumne* *NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.*
California PPO Counties	*N/A*
California Indemnity Counties	*N/A*

Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location or look for providers at www.metlife.com by ZIP Code.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*N/A*
What is the minimum percentage of employees required in CA?	*100%*
What states are allowed (or not allowed) for out-of-state coverage?	*Only Coverage in California is allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*N/A*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*N/A*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

May be offered dual choice (separate bill)

PROVIDER NETWORKS

DHMO Network	*SmileSaver Dental Plan/Metlife*

SmileSaver℠

SmileSaver℠

Provided by Safeguard Health Plans, Inc., A MetLife Company

RATING INFORMATION

	DHMO 1000, 2000, 3000 Plans:	DHMO "S" Plan
Group Size	2-999	5-999
Rate Guarantee	1 Year (2 years with approval)	
Rates Vary by Industry?	No	

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	DHMO 2-999	DHMO "S" Plans 5-999
Employees	N/A	N/A
For Dependents	N/A	N/A
% of Total Cost	N/A	N/A

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	DHMO 1000/ 2000/3000 2-999	DHMO "S" Plans 5-999
Employees	N/A	N/A
Dependents	N/A	N/A
NON-CONTRIBUTORY		
Employees	N/A	N/A
Dependents	N/A	N/A

OUT-OF-NETWORK CLAIM ADJUDICATION

DHMO: N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	Yes
Any ineligible industries?	No
Virgin groups eligible?	Yes
DE-9C statements required?	No

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	Yes
Management/Non-management?	Yes
Union/Non-union?	Yes
Minimum group size	2 for 1000, 2000 & 3000; 5 for 1000S, 2000S & 3000S

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

DHMO: No Waiting Period

SPECIAL CONSIDERATIONS

DHMO members must use a panel provider. Family members may each select their own dental office. Specialty care requires an approved referral.

Copays for covered services are listed in the DHMO Schedule of Benefits (SOB). Services must be performed by a panel general dentist or specialist. The SOB's also outline those specialty service procedures where the member's share of the cost will be at a discounted fee for service, not a copay. The "S" Plans include an expanded list of specialty service procedures covered at a copay.

A DHMO Group Application must be completed and submitted with employee applications or census enrollment. Group will be billed for 2 months initially.

Precious metals for restorative services, if used, will be charged to the DHMO member. Refer to the Schedule of Benefits and Evidence of Coverage for all Benefits, Exclusions and Limitations.

UnitedHealthcare®

CONTACT INFORMATION

Customer Service, Member Service, Commissions	*UnitedHealthcare HMO & DPO: 800-591-9911*
Claims	*HMO:* *P.O. Box 25181,* *Santa Ana, CA 92799-5181* *800-622-6388* *DPO:* *UnitedHealthcare Dental* *Attn: Claims Unit* *P.O. Box 30567* *Salt Lake City, UT 84130-0567* *800-445-9090*
Fax (Add-ons/Deletes)	*UnitedHealthcare 866-372-1316* *Email: clientserviceoperations@uhc.com*

CALIFORNIA COVERAGE

California HMO Counties*	*Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo & Yuba*
California DPO Counties	*All Counties*

**NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*HMO: No* *PPO: Yes*
What is the minimum percentage of employees required in CA?	*51% of the Eligible Employees. If there is not 51% of the eligible employees in any state, special guidelines apply. Contact your Word & Brown representative*
What states are allowed (or not allowed) for out-of-state coverage?	*HMO: CA* *PPO: All*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO, INO or indemnity*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rated based on Employer Zip Code*
Any other rules, restrictions, or guidelines not mentioned	*Contact your Word & Brown representative*

DUAL OPTION (MIX & MATCH)

HMO/PPO
- *Minimum of 5 eligible employees, 3 enrolling.*
- *Normal participation guidelines apply based on whether the group is voluntary or contributory, while meeting the minimum of 3 enrolled.*
- *A minimum of 10 eligible and 8 enrolled is required on any INO or PPO plan that includes orthodontic services.*

PPO/PPO
- *Minimum of 10 eligible employees, 10 enrolling.*
- *Normal participation guidelines apply based on whether the group is voluntary or contributory, while meeting the minimum of 10 enrolled.*
- *A minimum of 10 eligible and 8 enrolled is required on any option that includes orthodontic. If both plans include ortho, each plan will require a minimum of 8 enrolling.*
- *Combination of plans must be logical, e.g. high and low options.*
- *Plans must differ by more than just orthodontia on one plan.*

HMO/HMO
- *Minimum of 5 eligible employees, 3 enrolling.*
- *Normal participation guidelines apply based on whether the group is voluntary or contributory, while meeting the minimum of 3 enrolled.*
- *Combination of plans must be logical, e.g. high and low options. Target differential 30%*

VOLUNTARY
- *For Voluntary plans without Ortho benefits minimum of 2 enrolled for DHMO or DPPO plans*

PROVIDER NETWORKS

HMO Network *For DHMO plans - select 'CA Select Managed Care DHMO' for standard DHMO*	*www.myuhc.com*
DPO Network *For DPPO plans - select National Options PPO 20 or National Options PPO 30**	*www.myuhc.com*

** Options 30 designates UCR plans/Options 20 designates MAC/INO plans*

UnitedHealthcare®

UnitedHealthcare®

RATING INFORMATION

Group Size	*HMO: 2-99* *PPO: 2-99*
Rate Guarantee	*12 mo. rate guarantee*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	2-99	*2-99* *Voluntary*
Employees	*N/A*	*No employer contribution required**
For Dependents	*N/A*	
% of Total Cost	*50% for employer contribution†*	

**If employer contributes less than 50%, the group is considered voluntary.*
†Must meet participation requirement

PARTICIPATION

CONTRIBUTORY

	Group Size			
	2-99 HMO	*2-99 HMO (Vol.)*	*2-99 PPO*	*2-99 PPO (Vol.)*
Employees	◆◆ *75%*	*Min. 2*	◆◆ *75% of eligible employees, not less than 50%*	*Min. 2*
Dependents	*N/A*	*N/A*	*N/A*	*N/A*

** Must meet participation requirement*

NON-CONTRIBUTORY

Employees	*100%*	*100%*	*100%*	*100%*
Dependents	*N/A*	*N/A*	*N/A*	*N/A*

◆◆ *In order to NOT be considered eligible, the other coverage must be a group plan*

OUT-OF-NETWORK CLAIM ADJUDICATION

HMO	*N/A*
PPO	*Option of MAC or 85% of HIAA*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes—domestic households*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No—not on dental only groups as long as prior carrier (any product) list billing is provided*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*No*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

HMO & PPO: No Waiting Period on major services on takeover groups with credible coverage that includes type 3 service except for new hires or late entrants.

**Waiting periods may be waived for employees that can present proof of prior like coverage.*

**Guidelines only apply to plans sold with waiting periods. Other plans have no waits for initial enrollees or future hires.*

SPECIAL CONSIDERATIONS

An employer must be actively engaged in business or service for at least 45 days and have at least 2, but no more than 50 permanent, active, full-time eligible employees during this period.

Employees declining coverage must sign the Refusal of Employee and/or Dependent Coverage form. Not applicable for voluntary.

Packaged Savings discount are only available on employer paid ancillary coverage.

CONTACT INFORMATION

Member Service, Broker Services, Member Eligibility, Claims, Commissions, Billing, Add-ons/Deletes, Enrollment Status & Agent Portal Tech Support	*800-Ask-Unum (275-8686)*
Licensing/Contracting	*800-633-7491*
Sales & Product Information and Broker Relations, Tradeshow Requests or Marketing Materials	*Nick Burnham* *nburnham@unum.com* *For groups under 50, please contact:* *Cassie Moffatt* *cmoffat@unum.com*

CALIFORNIA COVERAGE

California PPO Counties	*All Counties*

Note: HMO dental coverage no longer offered

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*Need at least 10 total employees enrolled*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO only*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*CA ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

N/A

PROVIDER NETWORKS

PPO Network	*Always Care Network*

RATING INFORMATION

Group Size	*5+*
Rate Guarantee	*PPO: 1-3 year rate guarantee*
Rates Vary by Industry?	*Yes - All plans vary by industry*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	5+
Employees	*N/A*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	5+
Employees	*5+ enrolled minimum - those covered by another plan are not eligible in calculating participation.*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

90th and MAC

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*Yes—with underwriting approval*
Any ineligible industries?	*No*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Minimum 30 hours per week eligibility*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*5+ lives required*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Normally waiting periods are waived

SPECIAL CONSIDERATIONS

N/A

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VISION

RENEWAL INFORMATION - VISION

	Aetna	Ameritas	Anthem Blue Cross	BEST Life and Health Insurance Company
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Account client managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Contact support@gotodais.com. Send the renewing group name, broker name and ZIP code. The assigned Ameritas representative will call broker to assist.*	*Broker Services: 1-800-678-4466* *Account Manager as assigned to ACE agents* *Anthem Connect connect@anthem.com 877-567-1802*	*Broker Services Department 800-433-0088* *If adding a new line of coverage, please call assigned sales representative.*
Deadline for submission of group level renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*By the end of the renewal month*	*The completed documentation, including all necessary Anthem Blue Cross forms, must be received by Anthem Blue Cross within 30 days of the requested anniversary date. Non-anniversary benefit modifications will not be allowed.*	*Renewal changes at the group level can be made at the time of their renewal, prior to renewal effective date. For future renewal - if a group would like to have the changes made at their next renewal, we would have to process it before the invoice for that month is processed, which is more than 30 days. As for effective date, I would recommend 60-90 days before their renewal.*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*Request for plan changes to be effective on the renewal date must be submitted 10 days prior to the renewal date.*	*Within 30 days of qualifying event*	*A. Covered subscribers may move to a different product offered by their group at the anniversary month.* *B. A subscriber can request a change in medical benefits by completing the Employee Change Form or the Plan Change Request form on their group's anniversary date.*	*We have O/E open a month prior to their renewal month and continues through the end of the renewal month. In that window, the employee can make changes to their coverage.*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Brokers have access to Aetna's online enrollment system - e-enroll. They can run a report to view membership after changes are processed.*	*The broker may call Ameritas Agent Services to be set up on Ameritas Broker Portal for access. Call 855-517-5307, option 4*	*Yes - through Producer Toolbox at https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc*	*Yes - Broker Portal at: https://www.bestlife.com/brokers New users will need to contact 800-433-0088*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Contact dedicated Account Client Managers by phone or email.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Online when group is registered*	*Email or fax*	*Email: changes@bestlife.com or Online Broker Portal: https://www.bestlife.com/brokers*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Brokers can go to Producer World and access renewal online OR contact Account client managers designated by market with direct phone/email access.* *Account Client Manager Team: nationalSSCSmallGroup@aetna.com*	*Online when group is registered, or contact support@gotodais.com. Send the renewing group name, broker name and ZIP code. The assigned Ameritas representative will call broker to assist.*	*Through Producer Toolbox at https://brokerportal.anthem.com/ehb/web/bkr/acc/login.htm?wlp-brand=bcc*	*Call Broker Services Department 800-433-0088*
How far in advance do these receive their renewal material - Groups? Broker?	*Per CA law, brokers receive their renewals 60 days in advance of the renewal date. Brokers can view the renewals on Producer World as soon as they are mailed (usually 5-7 days in advance of mail).*	*At least 90 days*	*60 days. Brokers can also view the renewals on Producer Toolbox between 60-70 days.*	*60 days*

RENEWAL INFORMATION - VISION

	Blue Shield of California	CalCPA Health	CaliforniaChoice®	Camden Insurance Affiliate of Vision Plan of America	Guardian
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Producer Services 800-559-5905* *If related to up-selling Dental, Vision and Life, contact Account Manager.*	*Banyan Administrators: 877-480-7923*	*Renewals at 800-542-4218*	*Contact account manager 213-384-2600, ext. 1002* *erick@thecamden.com*	*Contact your Word & Brown representative, or call 800-459-9401*
Deadline for submission of group level renewal changes & their effective date?	*We prefer to receive changes by the 1st of the renewal month but will accept changes through the renewal month up to the last business day of the renewal month.*	*The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*Contact your Word & Brown representative*	*Contact your Word & Brown representative*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*We prefer to receive changes by the 1st of the renewal month but will accept changes through the renewal month up to the last business day of the renewal month.*	*The deadline for renewal changes varies slightly for different renewal months. The deadline is usually the second Friday of the month prior to the renewal date.*	*We prefer to receive changes by the 1st of the renewal month, but will accept changes through the renewal month up to the last business day of the renewal month.*	*Contact your Word & Brown representative*	*Contact your Word & Brown representative*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Yes - group level changes are done in the renewal center (SGOR tool). Employee level changes are done on employer connection plus. www.blueshieldca.com*	*Contact Banyan Administrators to gain system access*	*Yes: www.calchoice.com*	*No*	*Yes, through Broker Portal* *www.guardianantytime.com*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Any submission is 7-10 business days standard processing*	*Email*	*Fax or email*	*Email erick@thecamden.com*	*Contact your assigned Guardian Sales Representative*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Broker can pull a PDF copy of their renewal by logging into producer connection under online renewals*	*Call Banyan Administrators*	*Renewals at 800-542-4218*	*Contact account manager 213-384-2600, ext. 1002 erick@thecamden.com*	*Contact your Guardian Sales Representative, or call 800-459-9401*
How far in advance do these receive their renewal material - Groups? Broker?	*Approximately 90 days*	*60 days*	*60 days*	*60 days*	*75 days*

RENEWAL INFORMATION - VISION

	Health Net	Humana	Lincoln Financial Group	MetLife
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Account Management: 800-447-8812, option 2. Vision quote will show on group's renewal even if they do not have vision so they can review their options.*	*For group level quoting and negotiation you would contact your assigned retention executive. Member level questions, summaries or general group info, contact Market supports at 800-592-3005, or email sbmarketsupport@humana.com*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*Call Broker Services: 800-275-4638, option 3*
Deadline for submission of group level renewal changes & their effective date?	*The group has through the end of the month they are renewing in to make any changes. The effective date of these changes would be the 1st of their open enrollment month.*	*All plan changes must be received by the 5th of the month they are to be effective in. Example 4-1 plan change, must be received by 4-5 at the latest. Membership you have 30 days to collect and submit applications from the effective date. HOWEVER, we allow online enrollment up to 60 days past the effective date. The big thing to note if pushing the boundaries on this is that the app has to be signed within the O.E. window, when processing online it asks you when the document was signed and if it's outside of the 30 day window it won't be processed.*	*Contact your Word & Brown representative*	*For plan design changes we request that those are submitted prior to the effective date.* *For effective date changes we request that those are submitted 90 days in advance of the renewal anniversary.*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*For renewal changes on employee/ dependent coverage for Open Enrollment need to be received by the end of the month of the group's open enrollment month. If the probationary period has been met, the changes would be effective the 1st of the month of the group's Open Enrollment month.*	*All plan changes must be received by the 5th of the month they are to be effective in. Example 4-1 plan change, must be received by 4-5 at the latest. Membership you have 30 days to collect and submit applications from the effective date.* *HOWEVER, we allow online enrollment up to 60 days past the effective date.* *The big thing to note if pushing the boundaries on this is that the app has to be signed within the O.E. window, when processing online it asks you when the document was signed and if it's outside of the 30 day window it won't be processed.*	*Contact your Word & Brown representative*	*Adds/ Terms are continuous throughout the year and are dependent on the groups waiting periods*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Yes: https://www.healthnet.com/portal/broker/home.ndo Note: In order for a broker to have access to adds/terms, the Employer Group must first register on healthnet.com and give their broker permissions to such changes.*	*Yes via agent portal*	*No*	*Yes - Broker must submit application for MetLink portal metlink.com/*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Email or fax to Account Management.*	*Membership Changes made via broker or employer portal are the fastest (2+ space), fax is the slower method 866-584-9140. Group level plan changes should be sent to beclericals@humana.com* *Email enrollment is not available except through the broker portal secure messaging center. To check status, sbmarketsupport@humana.com or via phone 800-592-3005*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*Fax or email to service email address assigned to group*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Call Account Management at 800-447-8812 option 2*	*Agent Portal*	*2-99: Email Small Business Solutions at sbsRenewals@lfg.com*	*Call Broker Services: 800-275-4638, option 3*
How far in advance do these receive their renewal material - Groups? Broker?	*60 days for groups, 67+ days for brokers depending on renewal month*	*Around 75 days in advance, released on the 20th of a month.*	*60-90 days*	*75 days*

RENEWAL INFORMATION - VISION

	Nippon Life Benefits	UnitedHealthcare	Vision Plan of America	VSP
Where does a broker go with questions about a group's renewal? (Account Manager or 800 number)?	*Contact assigned Account manager 844-486-8471*	*Renewal account consultant*	*Contact account manager* *213-384-2600, ext. 1002 erick@visionplanofamerica.com*	*Call support team 800-216-6248 option 4*
Deadline for submission of group level renewal changes & their effective date?	*Contact your Word & Brown representative*	*Group level changes must be submitted by the 5th day of the effective month.*	*Contact your Word & Brown representative*	*VSP sends out renewal notices 90 days in advance. On our small group pooled business, we do not require a signature; rather, it is an auto-renewal whereby unless we are notified otherwise, the group's coverage will be renewed. In addition, we do not monitor a group's eligibility requirements such as hours per week and waiting periods. It is up to the client to manage and make membership updates online accordingly. Should they forget to make an update, they can contact the VSP service team and ask for an exception retro two months plus the existing month to obtain a credit. Any other changes such as changing a renewal date or upgrading a plan, etc., they should work with their VSP Client Manager. The Client Manager's name will always appear on the renewal notice*
Deadline for submission of employee/ dependent renewal changes & their effective date?	*Contact your Word & Brown representative*	*30th day of the renewal month.*	*Contact your Word & Brown representative*	*VSP sends out renewal notices 90 days in advance. On our small group pooled business, we do not require a signature; rather, it is an auto-renewal whereby unless we are notified otherwise, the group's coverage will be renewed. In addition, we do not monitor a group's eligibility requirements such as hours per week and waiting periods. It is up to the client to manage and make membership updates online accordingly. Should they forget to make an update, they can contact the VSP service team and ask for an exception retro two months plus the existing month to obtain a credit. Any other changes such as changing a renewal date or upgrading a plan, etc., they should work with their VSP Client Manager. The Client Manager's name will always appear on the renewal notice*
Do brokers have online access for tracking renewal changes such as adds/terms? If so, please provide website info	*Yes via Employer Portal, but must be approved by group*	*Yes: employerservices.com*	*No*	*No*
Which submission method offers the fastest processing time for renewal changes? (phone, fax, email or online)?	*Contact assigned Account manager 844-486-8471*	*Contact your Renewal Account Consultant*	*Email erick@visionplanofamerica.com*	*Email assigned client manager*
How does a broker secure a copy of a missing renewal? **(If broker needs to contact Account Manager and these are assigned by broker location or group's region please provide contact information list by broker location or group region.)**	*Contact assigned Account manager 844-486-8471*	*Broker should contact Renewal Account Consultant. Please see contact sheet.*	*Contact account manager 213-384-2600, ext. 1002 erick@visionplanofamerica.com*	*Call support team 1-800-216-6248, option 4*
How far in advance do these receive their renewal material - Groups? Broker?	*60 days*	*Approximately 60-75 days*	*60 days*	*90-120 days*

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CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*877-973-3238*
Commissions	*800-622-3435*
Claims	*Aetna Vision* *P.O. Box 8504* *Mason, OH 45040-7111* *877-973-3238*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*www.aetnavision.com*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*Call your Word & Brown representative*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All Plans are offered*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Vision has book rates for the entire 2-100 book of business.*
Any other rules, restrictions, or guidelines not mentioned	*None*

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*EyeMed Vision Care*
Indemnity Network	*N/A*

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RATING INFORMATION

Group Size	*2+*
Rate Guarantee	*4 years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2+
Employees	*N/A*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2+
Employees	*N/A*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes—if written standalone. Ineligible industries waived with prior employer-sponsored coverage*
Virgin groups eligible?	*Yes*
Wage & tax statements required?	*Upon request.* *Groups 6+: DE-9C, Prior Carrier Bill, Statement of Understanding and Proof of Eligibility Form - not required.* ** Tax documents may be requested at the discretion of the underwriter.*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*No*
Minimum group size	*2+*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

N/A

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CONTACT INFORMATION

Customer/Member Service	*855-517-5307*	
Dental & Vision Claims	*Option 1*	*Ameritas Group Claims PO Box 82520 Lincoln, NE 68501 group@ameritas.com Fax 402-467-7336*
Billing, Enrollment Status & Add-ons/Deletes	*Option 2*	*group_assistants@ameritas.com*
Directory Information	*Option 3*	
Sales & Product Information	*Contact your Word & Brown representative*	
BOR Changes	*Option 5*	*group_licensing@ameritas.com*
Broker Services, Tradeshow Requests or Marketing Materials	*Option 6*	*wbservices@gotodais.com*
Agent Portal Tech Support	*Option 8*	
VSP Claims	*800-877-7195*	*www.vsp.com*
EyeMed Claims	*866-289-0614*	*www.eyemedvisioncare.com*
Website	*www.ameritas.com*	

CALIFORNIA COVERAGE

California Vision Indemnity Counties	*All counties*
California Vision PPO Counties	*All counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, all employees.*
What is the minimum percentage of employees required in CA?	*No minimum requirement of employees located in CA; 3 if enrolled anywhere.*
What states are allowed (or not allowed) for out-of-state coverage?	*Employees can reside in any state and be covered. If the company situs location is WA or NY, not available. If the company situs is FL, there are separate rate brochures.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All. Plan designs subject to state laws*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Vision plans are nationally rated.*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

PROVIDER NETWORKS

PPO Network	*VSP Network Plus Affiliated for Focus Plans EyeMed Access Network for ViewPointe Plans*
Select Any Vision Provider	*MCE Vision Perfect Plan Flat Max Vision Perfect Plan*

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RATING INFORMATION

Group Size	*3+*
Rate Guarantee	*2 years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	3+
Employees	*N/A*
For Dependents	
% of Total Cost	

PARTICIPATION

CONTRIBUTORY	
	Group Size
	3+
Employees	*3+*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*3+*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Mail in for reimbursement. (If the member goes to Walmart, we have an arrangement that they will run the claim for the member.)

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*Eye doctors, all marijuana related businesses.*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*May be requested if 50% or more of group is related*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Offer to all eligible employees, no carve-outs*
Management/Non-management?	*Offer to all eligible employees, no carve-outs*
Union/Non-union?	*Allowed with underwriting approval*
Minimum group size	*3 enrolled*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Vision has no waiting periods or late entrant penalties.

Eligible employees can only elect or terminate coverage at open enrollment period each year, unless there is a qualifying life event.

SPECIAL CONSIDERATIONS

Discounts up to 10% for eyewear at Walmart.
Discounts at Walmart and Sam's Club for Prescriptions.

Simple Add-ons:
LASIK Advantage and HearingCare available for groups with a minimum of 10 or more enrolled lives.

Anthem BlueCross

CONTACT INFORMATION

Customer Service & Bilingual Support	*Blue View Vision℠ Customer Service* *Phone 866-723-0515*
Claims	*Blue View Vision℠ Customer Service* *Phone 866-723-0515*
Fax (Add-ons/Deletes)	*866-293-7373*
Broker Services	*800-678-4466* *casgbrokerservices@anthem.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All of California is eligible for Blue View Vision benefits.*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, coverage is offered out of state.*
What is the minimum percentage of employees required in CA?	*51% is required in CA.*
What states are allowed (or not allowed) for out-of-state coverage?	*All 50 states are available for out-of-state coverage.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All PPO plans are available for out of state employees.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*They are based upon the CA employer zip code.*
Any other rules, restrictions, or guidelines not mentioned	*Please see plan specific EOC.*

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*Blue View Vision*

Anthem BlueCross

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*24 Months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Vision	*Voluntary Vision*
Employees	*N/A (no employer contribution required as long as group meets participation.*	*Voluntary Plan would be used when participation cannot be met, voluntary requires only 5 to enroll.*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY		
	EmployeeElect	*Voluntary Vision*
Employees	*2-4: 65% with a minimum of 2 enrolled.* *5-100: 25% with a minimum of 2 enrolled.*	*5 enrolling employees*
Dependents	*N/A*	*N/A*
NON-CONTRIBUTORY		
Employees	*100%*	*5 enrolling employees*
Dependents	*N/A*	*N/A*

Please note: employees with group vision coverage do not count towards participation requirements.

OUT-OF-NETWORK CLAIM ADJUDICATION

PO Box 8504
Mason OH 45040-7111

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No, not allowed*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Wage & tax reports required?	*Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No, not allowed.*
Management/Non-management?	*No, not allowed.*
Union/Non-union?	*The group must be actively engaged in a business or service.* *On at least 50% of its working days during the previous calendar quarter or calendar year, the group employed at least one, but not more than 50, eligible employees, the majority of whom were employed within this state.* *The group was not formed primarily for purposes of buying a health care plan.* *A bona fide employer-employee relationship exists.* *A copy of the Union Roster will be required from the employer identifying Union members.*
Minimum group size	*2 enrolled*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Defined by the group

SPECIAL CONSIDERATIONS

Please see plan specific EOC.

BEST Life™
BEST Life and Health Insurance Company

CONTACT INFORMATION

Member Support, Customer Service & Commissions	*800-433-0088* *cs@bestlife.com*
Billing	*BEST Life and Health Insurance Co.* *P.O. Box 19721* *Irvine, CA 92623-9721*
Claims	*BEST Life and Health Insurance Co.* *P.O. Box 890* *Meridian, ID 83680* *800-433-0088* *Fax 208-893-5040* *Email: cs@bestlife.com*
Add-ons/Terminations	*Fax: 949-724-1603* *Email: changes@bestlife.com or* *Online Broker Portal: https://www.bestlife.com/brokers*

CALIFORNIA COVERAGE

California Vision Indemnity Counties	*All counties*
California Vision PPO Counties	*All counties*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*There is no minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*There are no restrictions.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO and Indemnity.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Rates are based on the CA employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*None*

PROVIDER NETWORKS

Indemnity Network	*No network required*
Vision PPO Network	*EyeMed's national Access PPO network*

BEST Life™
BEST Life and Health Insurance Company

RATING INFORMATION

Group Size	*5+*
Rate Guarantee	*1 year; 2 year rate guarantee for groups of 10+ employees enrolling when available.*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	Employer Sponsored 5+	*Voluntary Plans 5+*
Employees	*50%*	*0%*
For Dependents	*N/A*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

VOLUNTARY	
	Group Size
	5+
Employees	*5+ enrolled and 20% total participation. On groups where employer contributes 100%, 100% participation required.*
Dependents	*N/A*
EMPLOYER-SPONSORED	
Employees	*5+ enrolled and 60% total participation. On groups where employer contributes 100%, 100% participation required*
Dependents	*N/A*

Please note: employees with group vision coverage do not count towards participation requirements.

OUT-OF-NETWORK CLAIM ADJUDICATION

Claims payments are based on a per service maximum

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes - Optometry Offices/Clinics*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes - if the group has a carve out in place with prior carrier. Minimum of 5 enrolling.*
Management/Non-management?	*Yes - if the group has a carve out in place with prior carrier. Minimum of 5 enrolling.*
Union/Non-union?	*No*
Minimum group size	*Yes—available for groups with 5 or more enrolling*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

There are no waiting periods.

SPECIAL CONSIDERATIONS

Mid-month Effective Dates - Both 1st of the month and 15th of the month effective dates are offered.

Bundling Discounts - Save an additional 2-5% on dental with purchase of vision and/or life.

Voluntary groups that can demonstrate a 61% participation or greater enrollment rate will have the lower Employer Contributory rates as a reward.

blue of california

CONTACT INFORMATION FOR ALL VISION PLANS

Producer Services & Broker Services	*800-559-5905*
Commissions/BOR Changes	*800-559-5905*
Vision Member Services & Member Eligibility	*800-877-6372*
Enrollment Changes	*Blueshieldca.com/employer*
Accounting/Billing Department	*Blueshieldca.com/employer*
Vision Claims	*No claim forms are required for in-network services. Out-of-network form C4669-61 is available at Blueshieldca.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51%*
What states are allowed (or not allowed) for out-of-state coverage?	*All*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All PPO plans are available out-of-state; please check directory for available providers*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*CA employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*Employer paid groups from 1+, minimum participation 65% with minimum contribution at 25% and Voluntary groups from 1 enrolled minimum participation and 0% contribution.*

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*MESVision*
Indemnity Network	*N/A*

blue of california

RATING INFORMATION

Group Size	*All Contributory Plans: 1+ eligible* *All Voluntary Plans: 1+ enrolled*
Rate Guarantee	*All New Business Plans: 2 Years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size	
	1-100	*1-100 Voluntary*
Employees	*25%*	*0%*
For Dependents	*0%*	*N/A*
% of Total Cost	*N/A*	*N/A*

PARTICIPATION

CONTRIBUTORY		
	Group Size	
	1-100	*1-100 Voluntary*
Employees	*65%†*	*1 enrolled*
Dependents	*N/A*	*N/A*
NON-CONTRIBUTORY		
Employees	*100%*	*N/A*
Dependents	*N/A*	*N/A*

Rates are determined by the number of "eligible" employees; 1-50 rates vs 51-100 rates.

† *25% participation promotion available for groups of 5 or more enrolling. (Promotion end date at the discretion of Blue Shield). Healthcare exchanges are not eligible for this promotion. Refusals are required for all eligible employees not enrolling in the Blue Shield plans(s); unless vision plans are written without a Blue Shield medical plan. Blue Shield must be the sole carrier for dental, vision and life insurance plans.*

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Yes, 8811 Private Households*
Virgin groups eligible?	*Yes*
DE-9C statement required?	*Yes DE9C is required*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*Follow medical guidelines*
Minimum group size	*N/A*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

There are no waiting periods required by Blue Shield of California.

SPECIAL CONSIDERATIONS

Retirees are not eligible for coverage.

A group may add vision coverage off Anniversary at any time of the group's renewal date if the group's medical coverage is being recertified for eligibility. Groups can change to a different plan only at the anniversary date of the Blue Shield medical plan coverage or the anniversary date of the Blue Shield standalone vision plan coverage.

Blue Shield vision plans may not be offered along side another carrier's vision plans.

Only single option vision plan selection is available.

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

CalCPA Health

Health plans for CPAs since 1959

CONTACT INFORMATION

Customer Service, Bilingual Support, & Broker Services	*877-480-7923* *calcpahealth@calcpahealth.com*
Commissions	*714-567-4390*
Claims	*VSP: 1-800-877-7195*
Fax (Add-ons/Deletes)	*877-237-4519* *calcpahealth@calcpahealth.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*Coverage offered in all California counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51% of the group's employees must reside in California*
What states are allowed (or not allowed) for out-of-state coverage?	*All states allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Based on CA Employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*Group must also have medical coverage with CalCPA*

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*VSP Signature*
Indemnity Network	*N/A*

CalCPA Health

Health plans for CPAs since 1959

RATING INFORMATION

Group Size	*2+*
Rate Guarantee	*N/A*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2+
Employees	*100%*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2+
Employees	*100%*
Dependents	*100%*
NON-CONTRIBUTORY	
Employees	*N/A*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

VSP network

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*See "Special Considerations" section*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*N/A*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*No*
Minimum group size	*2+*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

Participation is available to the CA-based owners and employees of accounting firms in public practice or offering general financial services. To obtain and maintain eligibility as an employer, more than 50% of all of the employer's owners (i.e., principals, proprietors, partners, shareholders, or other owners) must be CPA Members of CalCPA, or Associate Members of CalCPA. All CalCPA Members must hold and maintain their CalCPA membership in good standing.

Groups can turn in apps for CalCPA membership with Enrollment. Membership ID# must be included on the Master App.

All employees must work 20 or 30 hours a week to enroll.

Groups must also have medical coverage with CalCPA.

CaliforniaChoice®
Your Health. Your Choice.®

CONTACT INFORMATION

Customer Service Center	*CaliforniaChoice 800-558-8003*
Member Service	*EyeMed (provided by Ameritas) - 866-289-0614* *VSP (provided by Ameritas) - 800-877-7195*
Broker Services & Commissions	*CaliforniaChoice - E-mail: commissions@calchoice.com* *Phone: 714-567-4390*
Vision Claims	*EyeMed (provided by Ameritas):* *EyeMed Vision Care* *Att: OON Claims* *P.O. Box 8504* *Mason, OH 45040-7111* *VSP (provided by Ameritas):* *Vision Service Plan* *Attn: Out-of-Network Provider Claims* *P.O. Box 997105* *Sacramento, CA 95899-7105*
Add-ons/Deletes	*CaliforniaChoice* *Fax: 714-558-8000*

CALIFORNIA COVERAGE

California Counties	*EyeMed (provided by Ameritas): All Counties* *VSP (provided by Ameritas): All Counties*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51%*
What states are allowed (or not allowed) for out-of-state coverage?	*All are allowed except Hawaii*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*Voluntary Vision*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*It is based on the employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

DUAL OPTION (MIX & MATCH)

PROVIDER NETWORKS

Vision Network	*EyeMed (provided by Ameritas): Select* *VSP (provided by Ameritas): Choice*

CaliforniaChoice®
Your Health. Your Choice.®

RATING INFORMATION

Group Size	*1-100*
Rate Guarantee	*12 Months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	1-100 Voluntary Only
Employees	*0%*
For Dependents	*0%*
% of Total Cost	*0%*

PARTICIPATION

NON-CONTRIBUTORY	
	Group Size
	1-100 Voluntary Only
Employees	*0%*
Dependents	*0%*

OUT-OF-NETWORK CLAIM ADJUDICATION

Varies based on service, see plan specific EOC/Certificate

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes-commission-only employees are eligible if they have a base salary that is at least minimum wage and are on the quarterly/annual wage report.*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Quarterly/Annual Tax report required?	*Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*No*
Management/Non-management?	*No*
Union/Non-union?	*Yes-coverage available for non-union only. Group must submit union billing to underwriting for verification that all other employees have medical coverage.*
Minimum group size	*1*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

Enrollment of spouse and children is contingent on employee enrollment.

CIA

The Camden Insurance Agency
An affiliate of Vision Plan of America

CONTACT INFORMATION

Broker Service/Commissions	*213-616-0640* *3250 Wilshire Blvd., #1610* *Los Angeles, CA 90010*
Avesis Claims/Member Services	*800-522-0258*
Avesis Eligibility Dept. Adds/Terms	*Fax 866-871-1638*
Avesis Customer Care Department	*800-828-9341*
Email	*Phil@theCamden.com*

CALIFORNIA COVERAGE

Avesis California Insured Vision Plan Counties	*All Counties*
California Indemnity Counties	*N/A*

The Avesis Insured Vision Plan is brought to you by Camden Insurance, an affiliate of Vision Plan of America, and is underwritten by Fidelity Security Life. Policy #VC-16; Form M9059

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes—nationally*
What is the minimum percentage of employees required in CA?	*Minimum 5 enrolled for employer-paid.* *Minimum 10 enrolled for voluntary.* *No minimum percentage required.*
What states are allowed (or not allowed) for out-of-state coverage?	*All states covered*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*Insured Vision Plan only*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Single rate for all areas*
Any other rules, restrictions, or guidelines not mentioned	*Employer paid groups: minimum employer contribution of 75% or 50% if tied to medical.*

PROVIDER NETWORKS

Insured Vision Plan	*Avesis* *www.avesis.com* *Plan #905*
Indemnity Network	*N/A*

CIA

The Camden Insurance Agency
An affiliate of Vision Plan of America

RATING INFORMATION

Group Size	*5+ employer-paid* *10+ voluntary*
Rate Guarantee	*2 years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	5+ employer-paid *10+ voluntary*
Employees	*75% of employer-paid or* *50% if tied to medical* *0% for voluntary*
For Dependents	
% of Total Cost	

PARTICIPATION

CONTRIBUTORY	
	Group Size
	5+ employer-paid *10+ voluntary*
Employees	*75% of employer-paid or* *50% if tied to medical*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*75% of employer-paid or* *50% if tied to medical*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Each 15 days

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes—with payroll deduction*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*N/A*
Management/Non-management?	*N/A*
Union/Non-union?	*N/A*
Minimum group size	*5 - employer-paid* *10 - voluntary*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

No waiting periods
*No pre-approvals**

**Except for medically necessary contact lenses*

SPECIAL CONSIDERATIONS

Camden offers Chiropractic and Acupuncture benefits as a bundle to Vision and Dental programs. 30 visits per year, $20 copayment per visit - Please contact your Word & Brown representative for more details.

Limitations: This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from: 1) Orthoptics of vision training; 2) Subnormal vision aids and any supplemental testing; 3) Plano (non-prescription) lenses, sunglasses; 4) Two pair of glasses in lieu of bifocal lenses; 5) Any medical or surgical treatment of eye or support structures; 6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services; 7) Any eye examination or corrective eyewear required by an employer as a condition of employment; 8) Services or materials provided as a result of Workers Compensation Law, or similar legislation, required by any governmental agency whether Federal, State or subdivision thereof.

Guardian®

CONTACT INFORMATION

Customer Response Unit	*(available to employees, employers and brokers)* *1-800-627-4200* *cru@glic.com*
Administration and Self-Service Portal	*(available to employees, employers and brokers)* *www.GuardianAnytime.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*We offer our Vision networks in all California counties and can provide network access analysis reports for a specific group during the quoting process.*
California Indemnity Counties	*N/A*

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes, our Vision plans offer nationwide coverage. Plans may be quoted include out-of-state employees.*
What is the minimum percentage of employees required in CA?	*There are no requirements for the minimum percentage of employees in California, however to be a considered a situs, there would need to be one officer located in the state.*
What states are allowed (or not allowed) for out-of-state coverage?	*Not applicable; however, plan design is based on employer location, so some state variations may apply.*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*There are some limitations and variations on what we can offer depending on the specific state regulation.*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Premiums are based on the employer location. Provider services are reimbursed based on the fee schedule or reasonable and customary reimbursement, based on the provider ZIP Code.*
Any other rules, restrictions, or guidelines not mentioned	*Benefits are quoted based on state requirements.*

DUAL OPTION (MIX & MATCH)

We can offer dual option plans for Guardian Vision and VSP or Davis Vision and VSP.

PROVIDER NETWORKS

Vision PPO Network	*Guardian offers our Guardian Vision network as well as VSP and Davis Vision*

Guardian®

Guardian®

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*1 year*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-100
Employees	*No limitations*
For Dependents	*No limitations*
% of Total Cost	*No limitations*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-100
Employees	*No limitations*
Dependents	*No limitations*
NON-CONTRIBUTORY	
Employees	*No limitations*
Dependents	*No limitations*

OUT-OF-NETWORK CLAIM ADJUDICATION

We can offer out-of-network coverage on most plans. Typically members would receive a reimbursement up to the limits of the specified out of network schedule.

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*Yes, generally subject to UW review*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Wage & tax reports statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*No*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

Dependent on case.

SPECIAL CONSIDERATIONS

Each case stands on its own merits and will be evaluated separately. Any special considerations will be provided during the quoting stage.

Health Net®
Vision

CONTACT INFORMATION

Member Service	*866-392-6058*
Broker Services/Commissions	*800-448-4411, Option 4*
Fax (Add-ons/Deletes)	*Fax 916-935-4420* *Email: enrollmentunit_north@healthnet.com*
Claims	*Send OON vision claims and itemized receipts to:* *Health Net Vision* *Attn: OON Claims* *PO Box 8504* *Mason, OH 45040-7111* *Fax: 866-293-7373* *Email: oonclaims@eyemedvisioncare.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*51%*
What states are allowed (or not allowed) for out-of-state coverage?	*Vision - all states allowed*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Not applicable for vision plans*
Any other rules, restrictions, or guidelines not mentioned	*Refer to Vision Underwriting Guidelines for more information*

PROVIDER NETWORKS

PPO Network	*Health Net Vision uses EyeMed's Access Network.*

Health Net®
Vision

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*12 months (note: groups requesting vision off-cycle, a short contract will be granted to align their vision renewal with medical).*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-100
Employees	*A minimum employer contribution of 50% of the employee premium is required for employer paid rates. A minimum of 2 active subscribers is required*
For Dependents	*There is no minimum contribution or participation requirement for dependents.*

PARTICIPATION

	Group Size
	2-100
Employees	*A minimum employer contribution of 50% of the employee premium is required for employer paid rates. A minimum of 2 active subscribers is required.*
Dependents	*There is no minimum contribution or participation requirement for dependents.*

OUT-OF-NETWORK CLAIM ADJUDICATION

Please refer to plan design

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Yes*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Carve outs are not allowed*
Management/Non-management?	*Carve outs are not allowed*
Union/Non-union?	*Carve outs are not allowed*
Minimum group size	*Carve outs are not allowed*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

None

SPECIAL CONSIDERATIONS

All employees, with the exception of the owners, must be covered by workers' compensation

Humana

CONTACT INFORMATION

Customer Service	*1-888-666-5733*
Broker Services	*1-800-592-3005*
Add-ons/Deletes	*1-866-584-9140*
Claims	*1-800-592-3005*

CALIFORNIA COVERAGE

California HMO Counties	*All counties*
California PPO Counties	*All counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*N/A*
What states are allowed (or not allowed) for out-of-state coverage?	*All states are allowed except Oregon, Washington, Montana, Wyoming, Rhode Island and Delaware*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Employer ZIP code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

PROVIDER NETWORKS

Vision Network	*Humana Vision Insight Network*

Humana

Humana

RATING INFORMATION

Group Size	*1-100*
Rate Guarantee	*24 months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	1-100 with dental *5-100 standalone*
Employees	*No limitations*
For Dependents	*No limitations*
% of Total Cost	*No limitations*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	1-100 with dental *5-100 standalone*
Employees	*50% (minimum 2) with dental* *50% (minimum 5) standalone*
For Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*Minimum 2 with dental* *Minimum 5 standalone*
For Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*Yes*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*2*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

N/A

CONTACT INFORMATION

Customer Service, Bilingual Support & Broker Services	*800-423-2765* *Brokers enter prompt 4* *Admin Support: prompt 2* *Providers: prompt 3*
Commissions	*800-423-2765* *Brokers enter prompt 4*
Claims	*1-800-440-8453* *Monday-Friday 5:00am PST – 8:00pm PST* *Saturday 6:00am PST – 3:30pm PST* *www.lvc.lfg.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*No County Restrictions*
California Indemnity Counties	*All*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*0%*
What states are allowed (or not allowed) for out-of-state coverage?	*N/A*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO plans*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Out of State ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

PROVIDER NETWORKS

PPO Network	*1-800-440-8453* *Monday-Friday* *5:00am PST – 8:00pm PST* *Saturday 6:00am* *PST – 3:30pm PST* *www.lvc.lfg.com*

Lincoln Financial Group®

RATING INFORMATION

Group Size	*2-99 Lives*
Rate Guarantee	*1 year or 2 years*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-99
Employees	*0%*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-99
Employees	*0*
For Dependents	*0*
NON-CONTRIBUTORY	
Employees	*0*
For Dependents	*0*

OUT-OF-NETWORK CLAIM ADJUDICATION

Must pay out of pocket and file claim for reimbursement

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Wage & Tax statement required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*2-99*

WAITING PERIOD WAIVER/TAKEOVER

Varies based on quote. Refer to proposal. Typically, waiting period is matched with previous plan and prior service credit is given.

SPECIAL CONSIDERATIONS

N/A

MetLife®

CONTACT INFORMATION

Customer Service	*1-800-ASK-4-MET (1-800-275-4638)*
Broker Services	*888-653-8325* *ask4met@metlifeservice.com*
Add-ons/Deletes	*Fax 888-505-7446* *Irvine_service@metlifeservice.com*
Claims	*MetLife Vision Claims* *PO Box 997565* *Sacramento, CA 95899-7565*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*75%*
What states are allowed (or not allowed) for out-of-state coverage?	*All PPO plans pay out-of-network benefits reimbursement only*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*All PPO plans are available out-of-state*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*One rate for all in and out-of-state employees*
Any other rules, restrictions, or guidelines not mentioned	*No*

PROVIDER NETWORKS

HMO Network	*N/A*
PPO Network	*MetLife Vision PPO Network/* *VSP Choice Network*
Vision Network	*N/A*

MetLife®

RATING INFORMATION

Group Size	*5-99 - preference is to sell with dental*
Rate Guarantee	*24 months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	5-99
Employees	*0%*
For Dependents	*0%*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	5-99 - min. of 5 and 10% participation
Employees	*10%*
For Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*100%*
For Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes*
Are 1099 employees allowed?	*No*
Any ineligible industries?	*None*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes—a minimum of 5 enrolled employees*
Management/Non-management?	*Yes—a minimum of 5 enrolled employees*
Union/Non-union?	*Yes—a minimum of 5 enrolled employees*
Minimum group size	*5-9 - preference is to sell with dental* *10+ - preference is to sell with dental*

WAITING PERIOD WAIVER/TAKEOVER

There are no waiting periods required. A group may impose its own waiting period

SPECIAL CONSIDERATIONS

N/A

Nippon Life Benefits®

CONTACT INFORMATION

Customer Service	*800-374-1835 (English)*
Broker Services	*800-374-1835 (English)*
Commissions	*800-374-1835 (English)*
Claims	*800-374-1835 (English)*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All CA counties available*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*No Minimum*
What states are allowed (or not allowed) for out-of-state coverage?	*NH*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*CA unless multiple locations*
Any other rules, restrictions, or guidelines not mentioned	*No*

PROVIDER NETWORKS

Vision Network	*EyeMed*

Nippon Life Benefits®

RATING INFORMATION

Group Size	*2-100*
Rate Guarantee	*1 or 2 years*
Rates Vary by Industry?	*Yes*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	2-100
Employees	*50*
For Dependents	*0*
% of Total Cost	*0*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	2-100
Employees	*25%*
For Dependents	*0*
NON-CONTRIBUTORY	
Employees	*25%*
For Dependents	*0*

OUT-OF-NETWORK CLAIM ADJUDICATION

Contact your Word & Brown representative

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Are 1099 employees allowed?	*No*
Any ineligible industries?	*Yes*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*No Union*
Minimum group size	*2+*

WAITING PERIOD WAIVER/TAKEOVER

SPECIAL CONSIDERATIONS

UnitedHealthcare®

CONTACT INFORMATION

Customer Service	*800-638-3120* *M–F 8:00 AM-11:00 PM* *Saturday 9:00 AM-6:30 PM EST* *www.myuhcvision.com*
Broker Services/Commissions	*Call your Word & Brown representative* *800-591-9911*
Fax (Add-ons/Deletes)	*866-372-1316* *Email: clientserviceoperations@uhc.com*
Claims	*UnitedHealthcare Vision Claims Dept.* *P.O. Box 30978* *Salt Lake City, UT 84130*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*50%; if greater, other state's rates may apply*
What states are allowed (or not allowed) for out-of-state coverage?	*All states eligible*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*Employer ZIP Code*
Any other rules, restrictions, or guidelines not mentioned	*No*

PROVIDER NETWORKS

PPO Network	*National Network* *Lasik surgery - Qualsight* *Members can access the vendor page by visiting myuhcvision.com.* *Qualsight* *1.855.321.2020*

UnitedHealthcare®

RATING INFORMATION

Group Size	*2-99*
Rate Guarantee	*24 months*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size		
	Employer Paid	*Buy-up*	*Voluntary*
Employees	*75-100%*	*75-100%*	*0-49%*
For Dependents	*75-100%*	*N/A*	*N/A*
% of Total Cost	*75-100%*	*N/A*	*N/A*

PARTICIPATION

	Group Size		
	Employer Paid	*Buy-up*	*Voluntary*
Employees	*75% eligible employees (excluding waivers) not to fall below 50% of all eligible employees*	*75% eligible employees (excluding waivers) not to fall below 50% of all eligible employees*	*Minimum of 2 eligible, 1 enrolled*
Dependents	*N/A*	*N/A*	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

Call your Word & Brown representative

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*No*
Any ineligible industries?	*Domestic households*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*Yes – DE-9C, 2 weeks payroll or prior carrier bill*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*2*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

Combine medical with one or more specialty products for administrative credits on your monthly invoice:

- *Medical + dental: $3.00 per employee per month*
- *Medical + vision: $2.00 per employee per month*
- *Medical + life and disability: $2.00 per employee per month*
- *Medical + life: $1.00 per employee per month*

Any combination of life products (i.e., basic life, dependent life, supplemental life, AD&D) counts as one product. Any combination of disability products (i.e., STD, LTD) counts as one product for the purpose of the program; LTD must be bundled with life coverage to qualify for the program and be eligible for credit. PEPM savings is given as monthly credit, based on the number of enrolled UnitedHealthcare medical subscribers. May not be available in all states or for all group sizes. Packaged price is available as long as eligible benefits remain in force. Credits will be withdrawn when any medical or specialty coverage terminates.

CONTACT INFORMATION

Vision Plan of America Broker Services, Commissions & Member Eligibility Dept.	*3250 Wilshire Blvd., #1610 Los Angeles, CA 90010 800-400-4VPA (4872)*
Accounting/Billing Department	*213-384-2600 Ext. 1002*
Provider Relations Department	*213-384-2600 Ext. 1003*
Add-ons/Deletes	*800-400-4872 Fax 213-384-0084*
Email	*info@VisionPlanOfAmerica.com*

CALIFORNIA COVERAGE

California HMO Counties	*All counties California only*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*No out-of-state coverage for HMO plan*
What is the minimum percentage of employees required in CA?	*No minimum percentage required. Minimum 2 lives*
What states are allowed (or not allowed) for out-of-state coverage?	*No out-of-state coverage for HMO plan*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*N/A*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*N/A*
Any other rules, restrictions, or guidelines not mentioned	*N/A*

PROVIDER NETWORKS

HMO Network	*Visionplanofamerica.com/providers* *All providers operate in a "private practice" setting*

RATING INFORMATION

Group Size	*HMO: 2+*
Rate Guarantee	*2 years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

	Group Size
	HMO 2+
Employees	*50% for employer-paid or 0% for voluntary*
For Dependents	*N/A*
% of Total Cost	*N/A*

PARTICIPATION

CONTRIBUTORY	
	Group Size
	HMO 2+
Employees	*2+*
Dependents	*N/A*
NON-CONTRIBUTORY	
Employees	*2+*
Dependents	*N/A*

OUT-OF-NETWORK CLAIM ADJUDICATION

N/A

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes—with payroll deduction*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
DE-9C statements required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*N/A*
Management/Non-management?	*N/A*
Union/Non-union?	*N/A*
Minimum group size	*2 - employer-paid* *2 - voluntary*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

No waiting periods
*No pre-approvals**
No claim forms

**Except for medically necessary contact lenses*

SPECIAL CONSIDERATIONS

Limitations: This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from: 1) Orthoptics of vision training; 2) Subnormal vision aids and any supplemental testing; 3) Plano (non-prescription) lenses, sunglasses; 4) Two pair of glasses in lieu of bifocal lenses; 5) Any medical or surgical treatment of eye or support structures; 6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services; 7) Any eye examination or corrective eyewear required by an employer as a condition of employment; 8) Services or materials provided as a result of Workers Compensation Law, or similar legislation, required by any governmental agency whether Federal, State or subdivision thereof.

CONTACT INFORMATION

Customer Service & Bilingual Support	*800-877-7195*
Broker Services	*800-216-6248*
Commissions	*800-216-6248*
Claims	*800-877-7195*
Fax (Add-ons/Deletes)	*877-654-3727 or online at: www.vsp.com*
Directory Information	*www.vsp.com* *800-877-7195*
Member Eligibility and Enrollment & Billing Status	*www.vsp.com*
Licensing/Contracting	*800-216-6248*
Sales & Product Information, Agent Portal Tech Support and Broker Relations, Tradeshow Requests or Marketing Materials	*800-216-6248*
BOR Changes	*vspwestern@vsp.com*

CALIFORNIA COVERAGE

California HMO Counties	*N/A*
California PPO Counties	*All Counties*
California Indemnity Counties	*N/A*

NOTE: Plans may not be available in all ZIP Codes within a county. Check with your Word & Brown representative to confirm if coverage is available for your group location.

OUT-OF-STATE COVERAGE

Is coverage offered for out-of-state employees?	*Yes*
What is the minimum percentage of employees required in CA?	*VSP is not based on % enrollment:* • *75% or greater Employer paid for ees and deps: Minimum of 5 enrolled* • *75% Employer paid for employees, 0% employer paid dependents: Minimum of 10 enrolled* • *Voluntary, no employer contribution to ees or deps: Minimum of 10 enrolled*
What states are allowed (or not allowed) for out-of-state coverage?	*All states eligible*
What plans (or plan types, such as PPO, indemnity, etc.) are offered for out-of-state employees?	*PPO*
Are rates for out-of-state employees based on the CA employer ZIP Code or based on out-of-state ZIP Code?	*CA rates apply to clients headquartered in CA and apply to all employees regardless of what state they reside in. Rates are always based on the state in which the client is headquartered, regardless of the location of the employees.*
Any other rules, restrictions, or guidelines not mentioned	*No*

PROVIDER NETWORKS

PPO Network	*www.vsp.com/choice*

RATING INFORMATION

Group Size	*All Core Plans: 5-499* *All Voluntary Plans and Core Employee/ Voluntary Dependant Plans: 10-499*
Rate Guarantee	*2 years*
Rates Vary by Industry?	*No*

PLAN ELIGIBILITY REQUIREMENTS

Minimum Employer Contribution

Plan Name	Group Size	Contribution Requirements
VSP Core Employee/ Voluntary Dependents	*Minimum enrollment is 10 employees*	*Minimum 75% employer contribution for all eligible employees.* *Dependent coverage is voluntary and employee paid.*
Voluntary Plan	*Minimum enrollment is 10 Employees*	*100% Employee paid*
VSP Core Plan	*Minimum enrollment is 5 employees*	*Minimum 75% employer contribution for all eligible employees and dependents, or, if bundled, 100% of those enrolled in the medical or dental plan.*

OUT-OF-NETWORK CLAIM ADJUDICATION

Out of network claims based on VSP open access allowances

Claims processed within 5-15 business days

COVERAGE REQUIREMENTS

Are commission-only employees allowed?	*Yes—with payroll deduction*
Any ineligible industries?	*No*
Virgin groups eligible?	*Yes*
Wage & tax reports required?	*No*

CARVE OUTS*

Exclusions allowed by carrier:

Hourly/Salary?	*Yes*
Management/Non-management?	*Yes*
Union/Non-union?	*Yes*
Minimum group size	*Employer paid: minimum of 5 employees enrolled* *Voluntary: minimum of 10 employees enrolled* *Core employee/Vol. deps: minimum of 10 employees enrolled*

* *Indicates a well-defined class of employees which may be selected from (i.e. carved out of) the entire group for coverage.*

WAITING PERIOD WAIVER/TAKEOVER

N/A

SPECIAL CONSIDERATIONS

- *Nationwide PPO Network-86,000 points of access nationwide*
- *Free GetFIT program*
  Primary eye care
- *Fixed pricing on lens enhancements*
- *Guaranteed patient satisfaction thru network providers*
- *Diabetic outreach program*

VSP Core Employee/Voluntary Dependents
1. *THESE RATES ASSUME a minimum 75% Employer Contribution for ALL ELIGIBLE EMPLOYEES. DEPENDENT COVERAGE IS VOLUNTARY AND EMPLOYEE PAID.*
2. *MINIMUM ENROLLMENT IS 10 EMPLOYEES.*

Voluntary Plan
1. *100% Employee paid.*
2. *Enrollment is completely Voluntary.*
3. *Minimum enrollment is 10 Employees.*

VSP Core Plan
1. *THESE RATES ASSUME a minimum 75% Employer Contribution for ALL ELIGIBLE EMPLOYEES AND DEPENDENTS, or, if bundled, 100% of those enrolled in the medical or dental plan.*
2. *MINIMUM ENROLLMENT IS 5 EMPLOYEES.*

Word&Brown®

CHIROPRACTIC/ ACUPUNCTURE

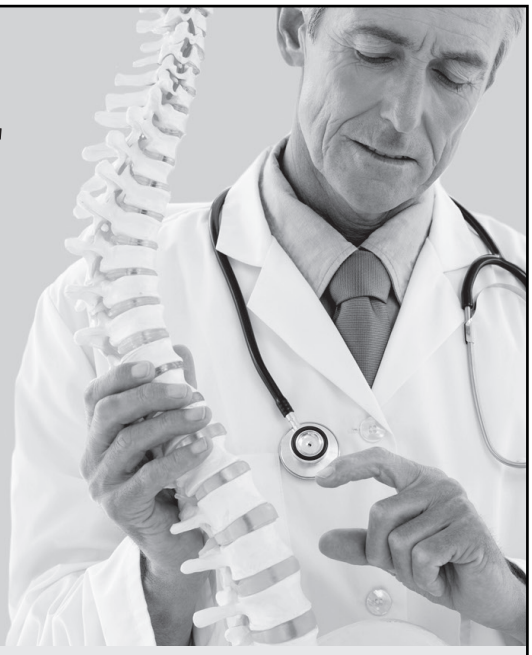
LANDMARK HEALTHPLAN℠

CONTACT INFORMATION

Member Support	*M-F 8:30 a.m.-5:00 p.m.* *800-298-4875, option 2; Fax 800-599-8350*	
Internet Support	*M-F 8:30 a.m.-5:00 p.m.* *800-298-4875, option 2; Fax 800-599-8350*	
Provider Eligibility Verification	*M-F 8:30 a.m.-5:00 p.m.* *800-298-4875, option 3; Fax 800-599-8350*	
Claims	*M-F 8:30 a.m.-5:00 p.m.* *800-298-4875, option 2; Fax 800-599-8350*	
Release Authorization (for HIPAA Release Forms)	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Customer Service	*M-F 8:30 a.m.-5:00 p.m.* *800-298-4875, option 2; Fax 800-599-8350*	
Commissions	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Adds/Terms	*Rhonda Clure* *Account Manager* *rclure@LHP-CA.com* *800-298-4875 x27712 or option 6 or 916-569-3312* *Fax 916-307-5250*	*Back-up: Greg Clure* *Vice President of Sales* *LIC # 0B81161* *gclure@LHP-CA.com* *916-569-3361; FAX 916-307-5250*
Administrator	*Greg Clure, Vice President of Sales* *LIC # 0B81161* *gclure@LHP-CA.com*	*Back-up: Rhonda Clure* *Account Manager* *rclure@LHP-CA.com*
Billing/Payments	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Broker of Record Changes	*Rhonda Clure* *Account Manager* *rclure@LHP-CA.com* *800-298-4875 x27712 or option 6 or 916-569-3312; Fax 916-307-5250*	*Back-up: Greg Clure* *Vice President of Sales* *LIC #0B81161* *gclure@LHP-CA.com* *916-569-3361; FAX 916-307-5250*
Cal-COBRA Department/ Federal COBRA Enrollments	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Small Group Cancellations/ Reinstatements	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Producer Service & Broker Service	*Greg Clure, Vice President of Sales* *LIC # 0B81161* *gclure@LHP-CA.com*	*Back-up: Rhonda Clure* *Account Manager* *rclure@LHP-CA.com*
Underwriting Department	*Group Services - GroupServices@evicore.com* *800-298-4875 x27750 or option 8 or 916-569-3350* *Fax 916-646-1263; https://securemail-evicore.com/*	*Register to our secure email system to communicate secure emails to the Group Service inbox.*
Broker Licensing Department/ Broker Licensing Paperwork	*Greg Clure, Vice President of Sales* *LIC # 0B81161* *gclure@LHP-CA.com*	*Back-up: Rhonda Clure* *Account Manager* *rclure@LHP-CA.com*

A New Answer To Your Clients' Pain Points

Chiropractic and Acupuncture Coverage from Landmark Healthplan



LANDMARK HEALTHPLAN℠

Chiropractic and acupuncture benefits are increasingly popular. Don't miss the opportunity to address a growing group need and earn a flat 10% commission.

Landmark offers a wide range of chiropractic and acupuncture benefits:

- Monthly premiums start at just $2.16 per employee and $6.27 for a family for a 20-visit, $20 co-pay Small Group Chiropractic Plan
- Premiums start at just $4.04 a month for an employee and below $11.70 monthly for a family for a combined chiropractic/ acupuncture services 20-visit, $20 co-pay plan
- No deductibles or coinsurance; office co-pays start at just $10
- Choice of 20 or 30 office visits annually
- Plans include X-ray services, emergency care, and acupuncture herbal therapies
- Easy underwriting: only enrollees with medical coverage are eligible; employer must contribute a minimum of 50% of Landmark plan premium

Landmark is the ONLY flexible chiropractic and acupuncture benefits provider available directly to employer groups in California.

- More than 1,600 chiropractic and acupuncture professionals statewide
- Utilization review fully accredited since 2008 by URAC
- 100% credentialed

Get started today! For more information, contact your Word & Brown representative.

Word&Brown®

800.869.6989 California | www.wordandbrown.com

Word&Brown®

ALTERNATIVE SOLUTIONS

Enroll Today!

Group Sponsored
Errors & Omissions Insurance for
Agents of
Choice Administrators, Inc.

Affordable and comprehensive Errors & Omissions Insurance for Life & Health Agents, delivered by CalSurance® and an admitted carrier rated A+ by AM Best*

- NO GROUP POLICY AGGREGATE – You do not share your limits with other enrolled agents
- Defense Outside the Limits – Defense costs do not erode your limit
- First Dollar Defense – You pay no deductible on defense costs
- Deductibles as Low as $500/claim – Deductible waiver also available
- Multiple Coverage Options – Purchase only the coverage you need
- New Agent Discounts Available
- Regulatory Defense Extension Included
- Personal Data Compromise (Cyber) Extension Included
- Limited Employment Practices Insurance (EPLI) Available
- Personal Lines P&C Coverage Available
- Flexible Payment Plans

See attached information for full program details.

** The information obtained from A.M. Best dated August 30, 2018 is not in any way CalSurance Associates' warranty or guaranty of the financial stability of the insurer in question, and that the information is current only as of the date of publication.*

Enroll Online in 5 Minutes or Less!

Visit: www.calsurance.com/choice

CalSurance®

A Division of Brown & Brown Program Insurance Services, Inc.
681 S. Parker Street, #300, Orange, CA 92868
Domiciled in California, CA License #0B02587

For more information contact CalSurance® at:
800-745-7189 (M-F, 7:00 a.m.-5:00pm PST)
info@calsurance.com

COMPNET

CONTACT INFORMATION

Mailing Address	*Berkshire Hathaway Guard* *P.O. Box 1368* *Wilkes-Barre, PA 18703*
Workers' Compensation Claims	*Berkshire Hathaway Guard* *1-888-639-2567* *https://www.guard.com*
Customer Service	*COMPNET Insurance Solutions, Inc.* *1-833-266-7638* *info@compnet-insurance.com*
Broker Relations	*COMPNET, David Bedard* *dbedard@compnet-insurance.com* *1-833-266-7638*
Workers' Compensation Payment Options **PAY AS YOU GO available** **No down payment or installment fees apply** **Payments can be made in conjunction with your payroll service** **COMPNET can work with any payroll service**	*For online payments, call: 800-673-2465 or go to: https://www.guard.com*
To submit a workers' compensation claim, documentation should include the following information	• *When calling, both the employer AND employee should jointly make the call whenever possible* • *The whole process should take about 15 minutes, and we do all the paperwork!* • *The employer's tax identification and policy numbers will be needed as well as the employee's social security number and personnel file plus any accident reports*
For instant workers' compensation quoting	*https://www.wordandbrown.compnet-insurance.com*


SAVE 10%
with EMPLOYERS & Anthem Blue Cross workers' compensation program!
COMPNET's target markets are 10-15% less than the competition!
Restaurant
Retail
Professional Office
Auto Service
Technology Company
COMPNET
W&B
1.508.397.7906
(266.7638)
1.833.COMPNET
info@compnet-insurance.com

EVOLVED BENEFITS

CONTACT INFORMATION

	TransConnect	TransChoice	SBMA MEC
Member Support	*888-763-7474* *TEBcustresp@transamerica.com*	*866-975-4641* *irvcustomerservice@amwins.com*	*888-505-7724, option 2* *updates@sbmamec.com*
Spanish Member Support	*Call your Word & Brown Representative*	*866-975-4641* *irvcustomerservice@amwins.com*	*888-505-7724, option 4* *updates@sbmamec.com*
Internet Support	*TEB_WebCoordinator@transamerica.com*	*N/A*	*updates@sbmamec.com*
Provider Eligibility Verification	*1-866-224-3100*	*866-975-4641*	*888-505-7724, option 1* *updates@sbmamec.com*
Claims	*1-866-224-3100*	*866-975-4641*	*888-505-7724, option 3* *updates@sbmamec.com*
Release Authorization (for HIPAA Release Forms)	*Call your Word & Brown Representative*	*irvcustomerservice@amwins.com*	*updates@sbmamec.com*
Customer Service	*888-763-7474* *TEBcustresp@transamerica.com*	*866-975-4641*	*888-505-7724, option 2* *updates@sbmamec.com*
Commissions	*Producer Portal on www.transamericabenefits.com or 800-400-3042, Option 4 or TEBcommissions@transamerica.com*	*irvcustomerservice@amwins.com*	*888-205-0186, option 8* *commissions@sbmamec.com*
Adds/Terms	*TEB_eligibilityservices@transamerica.com*	*irvcustomerservice@amwins.com*	*updates@sbmamec.com*
Administrator	*888-763-7474* *TEBcustresp@transamerica.com*	*irvcustomerservice@amwins.com*	*888-505-7724, option 2* *updates@sbmamec.com*
Billing/Payments	*866-411-4159, Option 3* *TEB_billingservices@transamerica.com*	*866-975-4641* *irvcustomerservice@amwins.com*	*888-205-0186, option 2* *billing@sbmamec.com*
Eligibility	*TEB_eligibilityservices@transamerica.com*	*irvcustomerservice@amwins.com*	*888-505-7724, option 2* *updates@sbmamec.com*
Broker of Record Changes	*tebcontracting@transamerica.com* *866-546-0997*	*866-546-0997* *tebcontracting@transamerica.com*	*888-205-0186, option 1* *sales@sbmamec.com*
Cal-COBRA Department/ Federal COBRA Enrollments	*Call your Word & Brown Representative*	*N/A*	*updates@sbmamec.com*
Small Group Cancellations/ Reinstatements	*Call your Word & Brown Representative*	*866-975-4641* *irvcustomerservice@amwins.com*	*Cancellations – updates@sbmamec.com* *Reinstatements – sales@sbmamec.com*
Producer Service & Broker Service	*800-400-3042, Option 3* *TEBcsproducers@transamerica.com*	*tebhealthclientservices@transamerica.com*	*888-205-0186, option 1* *sales@sbmamec.com*
Underwriting Department	*Call your Word & Brown Representative*	*tebhealthclientservices@transamerica.com*	*888-205-0186, option 4* *sales@sbmamec.com*
Broker Licensing Department/ Broker Licensing Paperwork	*New Agents: FACS Line: 866-546-0997 or fax: 866-945-8708* *Existing Agents: TEBcontracting@transamerica.com*	*866-546-0997* *tebcontracting@transamerica.com*	*888-205-0186, option 1* *sales@sbmamec.com*

EVOLVED BENEFITS

PROVIDER NETWORKS

	TransConnect	TransChoice	SBMA MEC
HMO Networks	*N/A*	*N/A*	*N/A*
PPO Networks	*N/A*	*MultiPlan*	*MultiPlan*
EPO Networks	*N/A*	*N/A*	*N/A*

UNDERWRITING & ENROLLMENT REQUIREMENTS

	TransConnect	TransChoice	SBMA MEC
Carrier's Effective Date	*1st or 15th of the month*	*1st of the month - Monthly* *First day of pay period - Paycycle*	*1st of the month*
Premium Amount Required for 15th?	*Call your Word & Brown representative*	*Call your Word & Brown representative*	*No premium required. Invoices will be run first of the month of the effective date unless billing in arrears then first of the month following the effective date*
Applications must be dated within	*60 days*	*60 days*	*N/A*
Spouse/Domestic Partner Employees - 1 application or 2?	*One application*	*One application*	*One application*

FEES

	TransConnect	TransChoice	SBMA MEC
Enrollment Fee Amount	*None*	*None*	*N/A*
Type of Enrollment Fee	*None*	*None*	*N/A*
Monthly Administration Fee	*None*	*None*	*Varies by plan*

24 HOUR COVERAGE

	TransConnect	TransChoice	SBMA MEC
Is Workers' Comp required on corporate offices, partners and sole proprietors?	*N/A*	*N/A*	*N/A*
Is on-the-job covered for corporate offices, partners and sole proprietors?	*If covered by underlying major medical*	*N/A*	*N/A*
Is there a premium adjustment for 24-hour coverage?	*N/A*	*N/A*	*N/A*

SPECIAL CONSIDERATIONS

EVOLVED BENEFITS

PLAN ELIGIBILITY REQUIREMENTS

Enrollment Group Size

	TransConnect		TransChoice		SBMA MEC	
	Initial	**After Issue**	**Initial**	**After Issue**	**Initial**	**After Issue**
Min. # of employees	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*10 Enrolled*	*10 Enrolled*	*25*	*25*
Max. # of employees	*No max*	*No max*	*No max*	*No max*	*No max*	*No max*

Minimum Employer Contribution

	Group Size		
	TransConnect	**TransChoice**	**SBMA MEC**
Employees	*Call your Word & Brown representative*	*No Employer Contribution required*	*No contribution required*
For Dependents	*Call your Word & Brown representative*	*No Employer Contribution required*	*No contribution required*
% of Total Cost	*Call your Word & Brown representative*	*No Employer Contribution required*	*N/A*

PARTICIPATION

Contributory

	Group Size		
	TransConnect	**TransChoice**	**SBMA MEC**
Employees	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*10 Enrolled*	*25 lives*
Dependents	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*10 Enrolled*	*N/A*
Non-Contributory			
Employees	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*10 Enrolled*	*25 lives*
Dependents	*Less than 100 eligible employees: 50% enrolled. 100+ eligible EEs: 25% enrolled.*	*10 Enrolled*	*N/A*

EVOLVED BENEFITS

COVERAGE RESTRICTIONS

	TransConnect	TransChoice	SBMA MEC
Are commission-only employees allowed?	*If covered by underlying major medical plan*	*Yes*	*No*
Are 1099 employees allowed?	*Call your Word & Brown representative*	*Call your Word & Brown representative*	*No*
Are employees covered if traveling out of USA?	*No*	*No*	*No*
Is coverage available for out-of-state employees?	*Yes*	*Yes*	*Yes*
Max. percentage of employees residing out-of-state allowed	*No max*	*No max*	*No max*

DIABETIC & SELF-INJECTABLE DRUG BENEFITS

Diabetes Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

		Insulin	Needles & Syringes	Chem-Strips and/or Testing Agents	Insulin Pump Supplies	Insulin Pump†	Glucose Monitor†
TransConnect	**Rx Drug Benefit**	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
	Medical/Durable Medical Equipment Benefit*						
TransChoice	**Rx Drug Benefit**	*Insulin only*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
	Medical/Durable Medical Equipment Benefit*	*N/A*					
SBMA MEC	**Rx Drug Benefit**	*Generic only*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
	Medical/Durable Medical Equipment Benefit*	*N/A*	*Not covered*	*Not covered*	*Not covered*	*Not covered*	*Not covered*

Self-Injectable Drug Benefits

Are the following items covered under the Prescription Drug Benefit or the Durable Medical Equipment Benefit of the member's selected plan design?

	Are self-injectable drugs (other than insulin) covered under the Prescription Drug Benefit or Medical Benefit?	Is pre-authorization required?	Must self-injectables (other than insulin) be purchased via the carrier-contracted mail order Rx vendor?
TransConnect	*N/A*	*Yes*	*N/A*
TransChoice	*N/A*	*No*	*N/A*
SBMA MEC	*N/A*	*N/A*	*N/A*

These services may change at any time without notice.
Please contact your Word & Brown rep for specific inquiries on listed services

For Prescription information, refer to comparison chart in the front of this guide.

Benefit information shown on this page is a brief summary. Limitations and exclusions apply.
Please refer to certificate book, evidence of coverage or call representative for details.

EVOLVED BENEFITS

CONTACT INFORMATION

Member Support	*Jerek Toves - Client Success Manager* *Phone: 602-734-9732* *Email: Jtoves@teladochealth.com*
Spanish Member Support	*HealthiestYou Member Services Line* *866-703-1259 ext. 2*
Internet Support	*HealthiestYou Member Services Line* *Phone: 866-703-1259 ext. 4* *Email: clientsuccess@teladoc.com*
Provider Eligibility Verification	*HealthiestYou Broker Support* *Phone: 866-703-1259 ext. 5* *Email: brokersupport@teladochealth.com*
Commissions	*HealthiestYou Broker Support* *Email: brokersupport@teladochealth.com*
Adds/Terms	*Jerek Toves - Client Success Manager* *Phone: 602-734-9732* *Email: Jtoves@teladochealth.com*
Renewals	*Dominic Luna - Manager, Renewals* *Phone: (623) 734-4876* *dluna@teladochealth.com*
Billing	*HealthiestYou Broker Support* *Email: accounting@healthiestyou.com*
Payments	*HealthiestYou Broker Support* *Email: accounting@healthiestyou.com*
Administrator	*Lauren Ozanich - Manager, Broker Sales* *Phone: 530-230-8281* *Email: Lozanich@teladochealth.com* *Jerek Toves - Client Success Manager* *Phone: 602-734-9732* *Email: Jtoves@teladochealth.com*

Teladoc HEALTH

HealthiestYou Complete Bundle

We believe healthcare should be hassle-free, so we made it that way.

Now there is even more to love about HealthiestYou. By combining the incredibly intuitive member-experience healthcare tools of HealthiestYou with the comprehensive family of virtual care services from Teladoc Health, employers can provide a complete bundle of the best virtual care has to offer. With the HealthiestYou Complete Bundle, employees don't need to worry about costly appointments, time wasted getting to and from doctors' offices, or if they are getting the best deal on a prescription. They have the tools to focus on what's important—getting back to living their healthiest life.

Fully integrated, $0-visit fee bundle for employer groups

number of employees	2-249	250-499	500-999	1,000-2,499	2,500-4,999	5,000+
PEPM individual + family	$16.00	$15.00	$14.00	$12.75	$11.50	$10.25

The HealthiestYou Complete Bundle provides more tools and virtual care solutions, including $0 visit fees.

General Medical
Convenient, high-quality healthcare available 24/7 from U.S. board-certified doctors by phone or video.

Behavioral Health Care
Members have access to licensed mental health professionals, with the option to receive ongoing care from a provider of their choice.

Expert Medical Services
In-depth reviews of existing diagnoses and treatment plans from the world's leading experts.

Dermatology
U.S. board-certified dermatologists review images and provide a diagnosis and treatment plan.

Back and Neck Care
Customized back care programs with videos and access to certified health coaches.

Dedicated Client Success Team
From implementation timelines to communication strategy and follow up, our dedicated Client Success Team will lay out the roadmap to ensure that every group is equipped with the tools to succeed.

Price Transparency Tools
Price-comparison engines help members make informed choices and save money on procedures and prescriptions.

Intelligent Alerts
Location-sensitive alerts delivering benefits reminders increase utilization of services.

Find a Provider
The HealthiestYou app can identify providers and facilities near the member's current location.

LEARN MORE

TeladocHealth.com | engage@TeladocHealth.com

About Teladoc Health
Teladoc Health is the global virtual care leader, helping millions of people resolve their healthcare needs with confidence. Together with our clients and partners, we are continually modernizing the healthcare experience and making high-quality healthcare a reality for more people and organizations around the world.

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Teladoc HEALTH

HealthiestYou Core Bundle

Members love the benefits, employers love the value.

Now there is even more to love about HealthiestYou. By combining incredibly intuitive member-experience healthcare tools with high-quality virtual care services, employers can provide the convenient, hassle-free virtual care employees want. With the HealthiestYou Core Bundle, employees don't need to worry about time wasted getting to and from doctors' offices, or if they are getting the best deal on a prescription. They have the tools to focus on what's important—getting back to living their healthiest life.

High-quality virtual care bundle including General Medical, Behavioral Health Care and Dermatology.

number of employees	2-99	100-249	250-499	500-999	1,000+
PEPM individual + family	$9.00	$8.00	$7.00	$6.00	Contact for quote

The HealthiestYou Core Bundle provides convenient access to these virtual care services and tools.

General Medical - $0 visit fee
Convenient, high-quality healthcare available 24/7 from U.S. board-certified doctors by phone or video.

Behavioral Health Care - $90-$220 visit fee
Members have access to licensed mental health professionals, with the option to receive ongoing care from a provider of their choice.

Dermatology - $85 visit fee
U.S. board-certified dermatologists review images and provide a diagnosis and treatment plan.

Dedicated Client Success Team
From implementation timelines to communication strategy and follow up, our dedicated Client Success Team will lay out the roadmap to ensure that every group is equipped with the tools to succeed.

Price Transparency Tools
Price-comparison engines help members make informed choices and save money on procedures and prescriptions.

Intelligent Alerts
Location-sensitive alerts delivering benefits reminders increase utilization of services.

Find a Provider
The HealthiestYou app can identify providers and facilities near the member's current location.

Learn more

TeladocHealth.com | engage@teladochealth.com

About Teladoc Health
Teladoc Health is the global virtual care leader, helping millions of people resolve their healthcare needs with confidence. Together with our clients and partners, we are continually modernizing the healthcare experience and making high-quality healthcare a reality for more people and organizations around the world.

Are Your Clients Covered?

Word & Brown is excited to provide you the opportunity to offer your clients international health insurance through **International Medical Group® (IMG®)**.

IMG™

Many travelers believe their domestic insurance plan will be enough when they travel abroad, but without the right plan, your clients may not be covered for an illness or injury.

Through International Medical Group (IMG) you can become contracted to offer your clients insurance coverage for individual, family and group plans to ensure they are protected when they travel.

One call. One company. Your single resource. IMG offers a full line of international medical insurance, trip cancellation and stop loss programs, as well as 24/7 emergency medical and travel assistance to meet the needs of anyone traveling or residing away from home

With IMG, you'll also be able to:

- Better serve your existing clients
- Attract new clients
- Write business worldwide
- Submit policies online, view production and much more

Here are a few other reasons why producers like working with IMG:

- Easy to offer the international products with customized on-line links
- IMG provides marketing support that will help you grow your business
- Multilingual consumer material and support for growing niche markets
- Market the international programs all year long with no open enrollment restrictions
- Continuous revenue stream and IMG producer incentive programs make working with IMG truly rewarding

For additional information please contact your **Word & Brown** sales representative.

Word&Brown®

The Holman Group

Turn to Holman for Full-Service Employee Assistance Programs

- **Our commissionable EAP is 100% employer sponsored.**
- **Our EAP provides employees free, face-to-face counseling sessions with local, licensed therapists. 3, 5, 6, 8, 10+ session plan models are available.**
- **Rates vary by employer based on the number of employees.**

The EAP Can be Used for Confidential Assistance with Problems Involving:

- Marriage & Family
- Stress & Anxiety
- Grief
- Adolescent Behavior
- Depression
- Legal & Financial
- Substance Abuse
- Job-related issues
- Emotional Difficulties

Our EAP Also Offers:

- **Toll-Free Crisis Line**: nationwide 800 number, staffed by licensed therapists, available in a crisis, 24/7/365.
- **Free Legal Consultations:** 30-minute phone consult with a licensed attorney for each separate legal matter. 25% discount if attorney services are retained after initial consultation.
- **Free Financial Consultations:** 60-minute phone consult with an expert financial manager for each money matter.
- **Legal/Financial Resource Center:** portal with self-help information on thousands of financial and legal issues, 45+ financial calculators, state specific legal forms and contracts, financial and legal educational materials.
- **Community Referrals**: child care, elder care, support groups, chemical dependency groups and more.
- **Free Kits:** will kit, end-of-life kit, retirement kit and estate planning checklist.
- **Medication Discounts:** free ScriptSave prescription discount card good at pharmacies nationwide.
- **Gym Discounts:** access to best-in-class gym membership pricing, apparel and wellness resources nationwide.
- **TicketsAtWork:** discounts on home goods, streaming services, food delivery, theatre, sports, movies, theme parks.
- **HolmanGroup.com:** access to topical weekly webinars, wellness articles, mental health resources and extra benefits.
- **Utilization Reports**: on line quarterly and annual reporting.
- **Unlimited Management Referrals:** training and guidance on referring employees to EAP for job-performance issues.
- EAP benefits extend to household members, including employee's lawful spouse and unmarried dependent children up to age 26, at no additional cost. All household members are covered, regardless of age or dependent status.

Additional Specialty Benefits:

- **Identity Theft Program-**provides a free, 60-minute consultation with a highly trained Fraud Resolution Specialist upon a data breach or identity theft incident.
- **Holman LifeSolutions & Holman ElderSolutions Programs-** referrals for a wider range of daily living, elder care, child care, adoption, college preparedness, prenatal service needs and more.
- **WellnessConnect Program-**helps members lead healthier lives by providing personalized health management tools and wellness resources.

The Holman Group
Managed Behavioral Health Care Services

For a Quote Call: 800-321-2843 **www.HolmanGroup.com**

Word&Brown®

WORKSITE VOLUNTARY

CONTACT INFORMATION

Mailing Address	*Aflac Worldwide Headquarters* *1932 Wynnton Road* *Columbus, GA 31999*
Claims	*800-992-3522* *Fax: 877-442-3522* *Email Claim: https://www.aflac.com/contact-aflac/contact-claims.aspx* *File a Claim: https://www.aflac.com/file-a-claim/default.aspx*
Customer Service	*800-992-3522* *Email Customer Service:* *https://www.aflac.com/contact-aflac/contact-customer-service.aspx*
Broker Relations	*877-772-3522*
Where do I mail my payment, including overnight payments?	*Mail payments to:* *Aflac* *1932 Wynnton Road* *Columbus, GA 31999* ***Please include your Aflac account/policy number on your check or money order.***
To submit a claim, documentation should include the following information:	• *Provider's name* • *Provider's address and phone number* • *Policyholder's Information* • *Patient Information* • *Dates of Service* • *Diagnosis* • *Specific treatment received from the provider*
ONE DAY PAY℠	*Many claims are processed in just one day. For more information, visit: https://www.aflac.com/onedaypay.* *To check the status of your claim online, login to Policyholder Services or call 800-992-3522 to speak directly to a customer service representative.*
Service Request	*Use the Aflac Group Service Request Form to request any of the following:* *a. Beneficiary Change* *b. Name Change* *c. Address Change* *d. Ownership transfer* *e. A copy of your certificate* *For your convenience, you can scan the signed and completed Service Request form and email it to cscmail@aflac.com or fax it to: 866-849-2974.* *You are also welcome to mail the Service Request Form to:* ***Continental American Insurance Company*** ***Post Office Box 84075*** ***Columbus, GA 31993*** *You can also access these Aflac Group Additional Forms:* *a. Authorization to Obtain Information Form* *b. Direct Deposit of Claims Payment Form* *c. Waiver of Premium Form*

Products, Services, and Enrollment Overview

YOU CHOOSE

We offer a wide selection of competitively priced insurance plans designed to meet the needs of your clients. From individual products to group products, Aflac has you and your clients covered.

Aflac insurance plans focus on employees' greatest financial exposure and probability of occurrence. Our market-leading coverage provides competitive rates and low expense ratios across the board.

INDIVIDUAL

Features

- Guaranteed-renewable
- Fully portable
- Historic rate stability
- Optional riders for greater employee choice

Products

- Accident
- Short-Term Disability
- Cancer/Specified-Disease
- Dental
- Hospital Confinement Indemnity
- Specified Health Event (Critical Care & Recovery)
- Hospital Intensive Care
- Life
- Hospital Confinement Sickness Indemnity
- Vision
- Lump Sum Critical Illness

GROUP

Features

- Guaranteed issue
- Consistency in plans, rates, and benefits
- Customizable plans for large accounts
- Ability to do group replacements
- Portable (while master policy in force)
- Available for clients with as few as 100 employees

Products

- Accident
- Critical Illness
- Short-Term Disability
- Whole Life
- Term Life
- Dental
- Supplemental Hospital Indemnity

For more information contact your local Aflac Broker Development Coordinator or visit aflac.com/brokers.

Colonial Life
The benefits of good hard work.

CONTACT INFORMATION

Experienced specialists are available to help you between 8 a.m. and 7 p.m. ET, Monday through Friday.

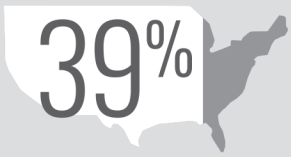
Plan Administrators	*1-800-256-7004*
Policyholders	*1-800-325-4368*
Group Billing	*P.O. Box 903* *Columbia, SC 29202*
Claims	*P.O. Box 100195* *Columbia, SC 29202*
Policy Holder Services	*Online: ColonialLife.com* *Log in and click on Contact Us* *Telephone: 1-800-325-4368* *Hearing-impaired customers: 803-798-4040* *If you do not have a TDD, call Voiance Telephone Interpretation Services. 844-495-6105*

Colonial Life
The benefits of good hard work.®

Powerful Partnerships

Word&Brown®

ONLY



of Americans would have enough savings to pay an unexpected expense of $1,000.[1]

Colonial Life's comprehensive portfolio includes:

- ACCIDENT INSURANCE
- CANCER INSURANCE
- CRITICAL ILLNESS INSURANCE
- DENTAL INSURANCE
- DISABILITY INSURANCE
- HOSPITAL CONFINEMENT INDEMNITY INSURANCE
- LIFE INSURANCE

Meeting your enrollment and voluntary benefits needs

No matter how hard we try to control it, life happens. That's why voluntary benefits are so critical. Your employees need protections for their families, finances and futures beyond core benefits – and you need a partner you can trust to help you do that.

Word & Brown believes in delivering exceptional value to our clients, which is why we've selected Colonial Life as a preferred partner for voluntary benefits. Our relationship is rooted in our shared ideals:

- Benefit flexibility and personalization are essential to employees
- Businesses and employees have different needs that deserve equal attention
- Communicating the value of benefits to employees
- Results are what matter most

What are voluntary benefits?

Also called "supplemental insurance," these benefits offer protections beyond major medical and other insurance coverages. They are often paid for by the employees themselves, allowing them to choose plans that meet their needs and goals.

They help employees personalize benefits packages to fit individual needs, including using them for co-pays or co-insurance, travel expenses, household bills and replacing wages or savings.

Colonial Life's offerings feature flexibility for your employees, so they can continue to have peace-of-mind.

Portability

- Keep coverage if employees retire or change jobs[2]
- Benefits paid regardless of other insurance coverage

Value Added Services[3]

- Access to programs like identity theft protection and AD&D coverage
- Help Increase enrollment
- Enhance coverage

Colonial Life enrolls billions each year in core medical benefits.*

*Internal Colonial Life data 2016.

Colonial Life makes the complex simple

Cost Management

- Increase employee cost sharing
- Boost tax savings
- Promote employee wellness

HR and Administrative Time Saving

- Streamline day-to-day benefits administration
- Help maintain compliance with employment laws
- Keep up with health care reform

Benefits Communication and Engagement

- Raise employee engagement
- Help employees understand their benefits
- Enable personalization of benefits plans

Employee Recruitment and Retention

- Provide robust benefits coverage
- Attract quality applicants
- Retain high-performing employees

They also empower participation through technology, while always providing personal assistance from their dedicated staff across the country.

Youville, a customizable education website for employees, is personally designed to help your employees determine the right benefits for their life, view personalized benefit recommendations, and ultimately take the mystery out of insurance.

www.visityouville.com/WordandBrown

Enrollment expertise and services

Colonial Life has a simple enrollment promise: educate and enroll employees in their benefits, all year round, at their convenience. Whether it be voluntary and core benefits or just voluntary, enrollment is a breeze. This yields even more benefits in the short and long-term.

With 6,300 nationwide enrollment coordinators, convenient employee administration tools and industry-leading benefit offerings, Colonial Life is ready to make your enrollment simple.

ColonialLife.com

Talk with your benefits representative for complete details.

1 Bankrate.com, Most Americans Don't Have Enough Savings to Cover a $1K Emergency, Jan.18, 2018.
2 Most coverage offered is portable.
3 Some programs require minimal participation.

11-18 | NS-16368

WBCompliance

Get the Compliance Help You and Your Clients Need

Our Team Makes Complicated Compliance Issues Simple

Introducing the WB*Compliance* team, your one-stop-shop for any compliance, employer reporting, or general regulation questions you or your clients may have. We're here to help you navigate the uncertainty of state and federal laws affecting you, your clients, and their employees. Here's what we cover:

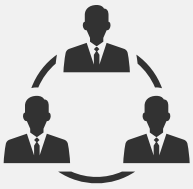
Compliance, Employer Reporting, and the ACA

Our team of compliance and Affordable Care Act (ACA) experts will answer your questions on annual employer reporting for Internal Revenue Service (IRS) Code Sections 6056 and 6055, waiting and lookback measurement periods, ACA exemptions, the employer and individual mandates (and penalties), rating structure changes, coverage gaps, premium tax credits, ERISA, and much more.

Human Resources Support and TPA Services

We deliver a wide range of human resources-related assistance and guidance, including access to a Human Resource Information System (HRIS) with online enrollment solutions. We also offer third-party administrator (TPA) services for COBRA, Premium Only Plans, Flexible Spending Accounts, ERISA Wrap documents, mandated employer letters, and Form 5500 preparation and filing.

(Note: Some TPA services are complimentary, while others are available at a discounted cost.)



Business Development and Retention

We'll help you grow – and retain – more business by helping you and your clients stay ahead of trends and changes. We offer an array of valuable tools and resources to ensure your clients stay compliant, including ACA calculators, IRS code and penalty references, customizable PowerPoint presentations, checklists, quick reference guides, a Flexible Spending Account/Health Reimbursement Arrangement/Health Savings Account comparison chart, and much more.

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Put us to the test!

Call us at **866.375.2039,** or email the team at **compliancesupport@wordandbrown.com.**

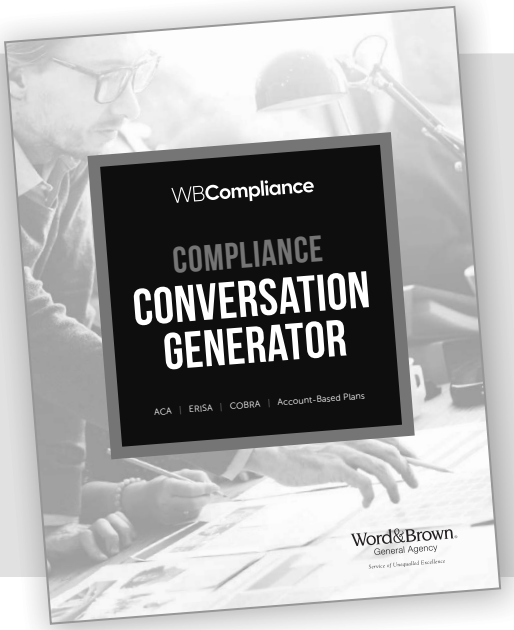
Continued on next page →

Committed to Compliance

Our team is committed to helping you and your clients cope with the evolving complexities of compliance as it relates to employee benefits and health insurance.

We offer a comprehensive array of Continuing Education (CE), HR Certification Institute (HRCI), and Society for Human Resource Management (SHRM) courses on compliance pitfalls, the ACA, HIPAA, ERISA, COBRA, HITECH, employee handbooks, and related matters. And we offer all of this information at no cost.

Our team collectively has more than 60 years of experience in the insurance industry – put our expertise to work for you and your clients.



Get the Conversation Started

Our exclusive ***Compliance Conversation Generator*** can help you start a dialogue with your clients about the changing health insurance industry, compliance, and its impact on their businesses.

This useful guide breaks compliance into simple-to-understand topics and includes important talking points you can address with your clients:

- Health reform and the ACA
- ERISA
- COBRA
- Account-based plans
- Premium Only Plans (POPs)
- Related other matters

With compliance audits on the rise, Department of Labor fines increasing, and ongoing discussions in Congress on the future of the ACA, more of your clients will be turning to you for help when it comes to compliance-related matters. With support from the WBCompliance team, you'll be able to offer the answers and resources your clients need – all at no cost to you or them.

Call or Email Us Today!

Whether your client is in California or Nevada, we're here to help you get answers to their specific questions.

We deliver answers to most inquiries in one business day.

Put us to the test!

Call us at **866.375.2039,** or email the team at **compliancesupport@wordandbrown.com**.

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WBQuote

Integrated Provider Search

WBQuote now offers integrated provider search, giving you the power to search, confirm, and build quotes with the doctors, medical groups, and hospitals your clients want, instantly!

Quote + Integrated Provider Search Offers You:

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Only present options that meet your clients' needs.

On-the-Fly Quote Adjustments

Add or remove providers in minutes.

One Click, Low-Cost Package Options

It's easy to add a carrier's lowest-cost package with the most preferred providers.

With our integrated provider search, you can also:

- Search and verify providers' contract status and carrier affiliations in one place
- Quote and present only the carriers and plans that align with your clients' preferences
- Easily see when a carrier's network will meet your client's needs
- Avoid third-party searches — or carrier website searches — and trying to match that information to what you're seeing in your quote
- Add providers and get a new quote in minutes, on location at your client's business

Start using your new Provider Search now!

Check it out at **wordandbrown.com/provider-search**.
Need help? Call your Sales Representative for a demo.

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We do.

That's just how committed we are.

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